County of San Diego
Health and Human Services Agency
Mental Health Services

Organizational Provider Operations Handbook

Adult/Older Adult Mental Health Services

for County Owned & Operated and Contracted Programs

Note:
The contract, including the Pro Forma and the Statement of Work, takes precedence over this Organizational Provider Manual.
If providers find any elements of the contract to be in conflict with this manual, please contact QI staff via email at
tess.widmayer@sdcounty.ca.gov)
and we will work with BHS Administration to resolve the matter.

[Appendix to Mental Health Plan]

Complete Revision December 18, 2009, Partial Revision October 2010

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ABBREVIATIONS REFERENCE GUIDE

ACL – Access and Crisis Line
AMHS – Adult Mental Health Services
A/OAMHS – Adult/Older Adult Mental Health Services
ASP – Augmented Services Program
ASW – Associate Social Worker (registered with the BBS)
BBS – Board of Behavioral Sciences
B&C – Board and Care
CA-QOL – California Quality of Life (client survey)
CMUMC – Case Management Utilization Management Committee
CCHEA – Consumer Center for Health Education and Advocacy
CCISC – Comprehensive, Continuous Integrated System of Care
CCR – California Code of Regulations
CCRT – Cultural Competence Resource Team
CFR – Code of Federal Regulations
CMHS – Children's Mental Health Services
CMS – County Medical Services
COTR – Contracting Officer's Technical Representative
CSS - Community Services and Support
DCS – Deaf Community Services
DHS – Department of Health Services (State of California)
DMH – Department of Mental Health (State of California)
DSM-IV-TR – Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
ECR – Error Correction Reports
EPU – Emergency Psychiatric Unit
FFP – Federal Financial Participation
FFS – Fee-For-Service
FSP – Full Service Partnership
FTE – Full-Time Equivalent
HHSA – Health and Human Services Agency
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
ICM – Intensive Case Management
IMF – Intern Marriage and Family Therapist (registered with the BBS)
IMD – Institute of Mental Disease
LCSW – Licensed Clinical Social Worker
LPS – Lanterman-Petris-Short (Conservatorship)
McFloop – Multi-Use Complete Feedback Loop
MFT – Marriage and Family Therapist

MHP – Mental Health Plan
MHSA – Mental Health Services Act
MHS – Mental Health Services
MHSIP – Mental Health Statistics Improvement Program
MIS – Management Information Systems
MORS – Milestones of Recovery Scale
MSR – Monthly Status Report
NOA-A – Notice of Action – Assessment
NOA –B – Notice of Action
OIG – Office of Inspector General
OP – Outpatient
Optum – OptumHealth
P&T – Pharmacy and Therapeutics Standards and Oversight Committee
PCR – Program Contract Representative (Program Monitor)
PEI – Prevention and Early Intervention
PSR – Psychosocial Rehabilitation
QI – Quality Improvement
QM – Quality Management
QRC – Quality Review Council
SMA – Statewide Maximum Allowances
SDCMHA – San Diego County Mental Health Administration
SDCPH – San Diego County Psychiatric Hospital
SF/LTC – Secure Facility/Long-Term Care
SNF/STP – Skilled Nursing Facility/Special Treatment Program
SOC – Systems of Care
TAR – Treatment Authorization Request
TBS – Therapeutic Behavioral Services
TBI – Traumatic Brain Injuries
UBH – United Behavioral Health
UM – Utilization Management
UMDAP – Uniform Method for Determining Ability to Pay
UR – Utilization Review
URC – Utilization Review Committee
USD – University of San Diego (Patient Advocacy Program)
W&IC – Welfare & Institutions Code (State of California)
WET – Work Force Education and Training

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A. SYSTEMS OF CARE (SOC)

Mission of Health and Human Services Agency (HHSA) Mental Health Services (MHS)

The mission of the Health and Human Services Agency is: "Through partnerships, and emphasizing prevention, assure a healthier community and access to needed services, while promoting self-reliance and personal responsibility." Mental Health Services adds to that mission: "To provide quality, cost-effective mental health treatment, care, and prevention services by dedicated and caring staff to people in the service population."

Client Population Served by the Mental Health Plan (MHP)

Clients with serious mental illness who are:

- Adults ages of 18-59
- Older adults age 60 and over
- Transitional Age Youth who will be turning 18 and transitioning from the children's mental health system into the adult mental health system
- Clients with co-occurring mental health and substance use
- Medi-Cal eligible
- Indigent

Psychosocial Rehabilitation and Recovery

Adult/Older Adult Mental Health Services (A/OAMHS) espouses the philosophy and practices of biopsychosocial rehabilitation and recovery in its system of care.

Psychosocial rehabilitation in a recovery-oriented system helps people with mental disabilities to: (1) learn to manage the symptoms of their disorder; (2) acquire and maintain the skills and resources needed to live successfully in the community; and (3) pursue their own personal goals and recognize and celebrate their individual strengths. The service focus is on normalization and recovery, and the person is at the center of the care planning process. Personal empowerment, the ability to manage one's disorder and move toward mastery of one's personal environment, is the path to recovery.

The psychosocial rehabilitation and recovery approach includes a variety and continuum of interventions and models, including, but not limited to, peer education, family education, clubhouses, skills development, resource development, housing support, job support, money management, and relapse prevention. Integration of this approach with needed medical services results in a comprehensive approach to recovery.

Additional information on San Diego County Systems of Care and psychosocial rehabilitation can be found in the System Redesign Implementation Plan for Adult/Older Adult Mental Health Services, 1999.

Services for Dual Diagnosis (Mental Illness and Co-occurring Substance Use Disorders)

San Diego County Adult/Older Adult Mental Health, Children's Mental Health Services and Alcohol and Drug Services, recognizes that clients with a dual diagnosis, a combination of mental illness and substance use disorders, may appear in all parts of the system. These conditions are associated with poorer outcomes and higher cost of care. Integrated treatment of co-occurring substance use and mental health diagnosis is recognized evidence-based practice.

A/OAMHS has adopted the Comprehensive, Continuous, Integrated System of Care (CCISC) model that espouses a treatment and recovery philosophy that promotes the integrated treatment of clients with mental illness and substance use issues. Individuals who meet mental health treatment eligibility criteria and who also have a secondary diagnosis of substance use shall receive treatment focused on the mental health diagnosis and the impact of the substance use issue. Upon intake to a mental health program, the presence of substance use by clients shall be assessed. During treatment, substance use is reassessed on an ongoing basis and discussed with the client in terms of its impact on and relationship to the primary mental health disorder. Client Plans shall clearly reflect any services that may be needed to address the co-occurring substance use problems. Progress notes shall meet all Medi-Cal and Title 9 documentation requirements and must list a mental health diagnosis or problem as the focus of the intervention.

To support the implementation of the Dual Diagnosis Initiative, Mental Health Services recommends the development of Dual Diagnosis Capable programs. Programs participating in the CCISC Initiative shall demonstrate the following to be considered dually capable:

- San Diego Charter adoption and implementation
- COMPASS completion
- Action Plan development
- Program Policies:
    - Welcoming Policy/Statement
    - MHS Co-occurring Disorders Policy
    - Other
- Training and supervision of staff in Integrated Treatment Practice Model
- Integrated Screening
- Integrated Clinical Assessment
- Integrated Psychiatric Assessment
- Implementing Stage of Change Interventions
- Measure of client progress as evidence in the client plan and in progress notes (Outcomes: stage of change level, number of relapses, reduction of alcohol/drug use by type, number of months clean and sober, other)

- QI Baseline Monitoring Tool compliance

For additional information on the Dual Diagnosis initiative, please refer to the County of San Diego Health and Human Services Agency, Adult/Older Adult Mental Health, Children's Mental Health Services, Alcohol and Drug Services Charter and Consensus Document for Co-occurring Psychiatric and Substance Abuse Disorders, March 2003; and the County of San Diego, Mental Health Services Policy and Procedures Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No. 01-06-117, February, 2004, and the HHSA, Dual Diagnosis Strategic Plan, 2002.

Services to Older Adults

Older adults living with mental illness comprise a segment of the population whose co-occurring health and social problems present ongoing challenges and opportunities for providers of adult mental health services. Recognizing the compounding effects of untreated mental illness on older adults (increased risk for institutionalization, hospitalization and medical services, increased mortality and social isolation, untreated medical illnesses, as well as the barriers that prevent older adults from accessing mental health services), San Diego County has taken steps to develop the Older Adult System of Care. To that effect, an Older Adult Mental Health Strategic Plan was developed and approved by San Diego County Board of Supervisors in October 2000. The Older Adult Mental Health Strategic Plan sets forth values and principles to guide the process of implementation of this three- to five-year plan. The Older Adult Mental Health Strategic Plan describes the vision, mission, and target population and makes policy recommendations for the implementation of an integrated, coordinated Older Adult System of Care that is age appropriate, cost effective, and based on best practices.

The mission of the Older Adult System of Care is to "ensure quality, cost-effective culturally competent, age-appropriate integrated mental health treatment, care, prevention and outreach services to older adults through a collaboration with consumers, advocates and other professionals and agencies working with the older adult community." Providers will participate in ongoing training regarding meeting the unique needs of our older adult clients. In addition, providers will participate in networking efforts with providers of collateral services for older adults, in order to continue to develop the system-wide capacity to meet these clients' mental health existent and future demands more adequately.

For additional information, please refer to the California Department of Mental Health, Older Adult System of Care Framework and the San Diego County Health and Human Services Older Adult Mental Health Strategic Plan, October 2003, President's Freedom Commission Report, Older Adults, 2004.

Services to Youth in Transition

In recent years, the existence of a significant mental health service gap for youths 18-24 transitioning from the Children's Mental Health (CMH) System of Care to the Adult Mental Health (AMH) System of Care has been identified as a serious issue. To address this issue, the County of San Diego, HHSA MHS has implemented the Youth Transition Services Plan. This plan identifies transitional youths' needs and existent resources, addresses services gaps, and makes recommendations to the AMH and CMH Systems of Care. This transition plan is the blueprint for the improvement of youth transition services within the mental health system.

The mission of the Youth Transition Services Plan is for CMH and AMH Systems of Care to work in partnership with youths on developing and implementing services that are developmentally and culturally appropriate. To accomplish this mission, both systems are working to address the unique needs of youths and to integrate a seamless referral process. Two sets of policies have been developed to support the implementation of this process. The Youth Transition Self-Evaluation Policy defines the process for identifying the mental health needs of transitional age youths and ensuring that comprehensive services are available to youths transitioning from the CMH system to the AMH system. The Transition Age Youth Referral Policy initiates a process for the transition of clients whose needs present unusual challenges for our system.

Adult and children's mental health providers shall coordinate with each other and seek appropriate consultation to ensure that the unique needs of this population are met. An ongoing team shall work to address issues regarding services and coordinate the varied agencies that provide services for this population. This group recently developed the Transitional Youth Resource Directory to ensure that those working with this population have accurate information on available services for these youths.

For additional information on the Youth Transition Services Plan, please refer to the County of San Diego, HHSA MHS, Mental Health Youth Transition Services Plan, July 2000, Transitional Age Youth Referral Policy (No. 01-01-114) and Youth Transition Self-Evaluation Policy (No: 06-01-113).

Peer-Supported Recovery and Rehabilitation Services

As with the fields of physical disability and alcohol and drug service, there is a long history of peer support within mental health services. The County of San Diego AMHS recognizes the value of mutual support and peer counseling and encourages programs to employ qualified people who bring consumer experience to their jobs. AMHS supports the provision of consumer-provided services throughout the system of care, including, but not limited to, outpatient clinics, case management programs and clubhouses. Volunteers also offer peer recovery services, and AMHS supports programs such as NAMI's Peer to Peer and Warm Line,

which offers volunteers the opportunity to use their consumer experiences to help educate and support others.

Providers shall utilize the talents of peer staff and volunteers in working with clients, as well as informing the efforts of professional staff. Providers will integrate the role of peer self-help groups, peer advocacy groups in outpatient programs and the regional Clubhouses as part of the client support system and as an adjunct to mental health services.

Homeless Outreach Services

Homeless Outreach Services are provided to individuals who are homeless and have a serious mental illness and/or substance use problem. Homeless outreach services consist of the following services:

- Outreach and engagement
- Screening and mental health assessment
- Referral and placement in emergency homeless shelters
- Short-term care coordination and case management services
- Linkages to mental health services, health services, social services, housing, employment services, advocacy and other needed services
- Coordination and collaboration with other providers to include psychiatric hospitals and other fee-for-service (FFS) providers

Homeless Funds

Homeless incidental funds are used for client-related needs including: food, clothing, transportation, and other incidentals necessary for accessing ongoing benefits.

Emergency Shelter Beds

The homeless outreach services workers are the gatekeepers and managers of the utilization of emergency and transitional short term shelter beds located in all the regions, with the exception of the South region. Participants utilizing these beds engage with the homeless outreach workers and Peer Support Specialists to work towards identified goals.
The County's program monitor reconciles the billing invoices on a monthly basis and oversees the utilization of these beds. The following is a current list of shelters utilized by the homeless outreach staff:

Broadway Home
Center for Community Solutions
Chipper's Chalet
United Homes
MPH Guest Home

North County Interfaith Council
Volunteers of America

Staff Productivity Standard:

Outpatient programs shall meet or exceed the minimum productivity standard for annual billable and non-billable time by providing at least 65,040 minutes per year (60% productivity level), unless otherwise specified in the program's Statement of Work.

Additional References:
Regional Homeless snapshot: Data source Service Point, prepared by the regional Task force on the Homeless.

Homeless Services Profile: An update on Facilities and Services for Homeless Persons throughout San Diego County.

Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and/or Co-occurring Substance Use Disorders, U.S. Department of Health and Human Services; Substance Abuse and Mental Health Services Administration Center for Mental Health Services; www.samhsa.gov.

B. COMPLIANCE AND CONFIDENTIALITY

The County of San Diego Health and Human Services Agency (HHSA) is committed to maintaining a culture that promotes the prevention, detection and resolution of instances of conduct that do not conform to laws, rules, regulations, or County policies or procedures.

County Compliance Programs

As part of this commitment, all County Mental Health Services employees are expected to be familiar with and adhere to the HHSA Compliance Program that includes all of the required elements of a compliance program as stated below. In addition, County Programs must have processes in place to ensure that they are adhering to all requirements in the HHSA Code of Conduct and Statement of Incompatible Activities, including but not limited to the Compliance Standards listed below.

For more information:

HHSA Code of Conduct and Statement of Incompatible Activities:
http://hhsa_intranet.co.san-diego.ca.us/policy/mpp/m/m1_2.pdf

HHSA Compliance Program:
http://hhsa_intranet.co.san-diego.ca.us/policy/index.html

Provider Compliance Programs

Each contractor is required to have an internal compliance program to ensure that all applicable Federal and State laws are followed. At all times during the term of the provider's contract, contractor shall maintain and operate a compliance program that meets the minimum requirements for program integrity as set forth in 42 CFR 438.608. Failure to establish and maintain a compliance program, as required by this section, shall be considered a material breach of the contract.

Elements of a Compliance Program

- Code of Conduct and Compliance Standards, as described below.
- Compliance Officer who is a senior manager charged with responsibility for overseeing and monitoring implementation of the compliance program.
- Communications which create avenues for employees to raise complaints and concerns about compliance issues, including billing fraud, without fear of retribution.
- Training and Education for employees regarding compliance requirements.
- Auditing and Monitoring Systems designed to reasonably detect and prevent potential violations of laws and regulations relating to health care and human services funding and programs.

- Enforcement and Disciplinary Actions, within labor guidelines, to enforce the program, including discipline of individuals for engaging in wrongful conduct or for failing to detect or report noncompliance.
- Response and Prevention, which consists of mechanisms to respond to and investigate all reasonable concerns regarding compliance and suspected noncompliance and of taking necessary corrective action to prevent recurrence.

Code of Conduct Standards

A Code of Conduct is a statement signed by all employees, contractors, and agents of an organization that promotes a commitment to compliance and is reasonably capable of reducing the prospect of wrongful conduct. Codes of Conduct should be created at the agency level.

Compliance Standards

All programs, both County and contracted, shall have processes in place to ensure at the least the following standards:

- Staff shall have proper credentials, appropriate experience and expertise when providing client treatment and services in the area in which they function.
- Staff shall accurately and completely document all client encounters in appropriate records in accordance with funding source requirements and County guidelines.
- Staff shall participate in activities that promote quality assurance and quality improvement and bring concerns regarding possible deficiencies or errors in the quality of care, treatment or services provided to clients to the attention of those who can properly assess and resolve the concern.
- Staff shall take reasonable precautions to ensure that billing and/or coding of client services are prepared and submitted accurately, timely, and in compliance with all applicable federal, State, local laws, rules and regulations and HHSA's policies and procedures.
- Staff shall provide that no false, inaccurate or fictitious claims for payment or other reimbursement are submitted, by billing only for eligible services actually rendered and fully documented. When coding for services, only billing codes that accurately describe the services provided will be used.
- Staff shall act promptly to report and correct problems if errors in claims or billings are discovered.

MHP's Compliance Hotline

The MHP has created a Hotline for its own staff, as well as Contractors, to report concerns about a variety of ethical, legal, and billing issues. The confidential Hotline is toll-free and available 24 hours per day, seven days per week. Callers may remain anonymous if they wish. The number of the Compliance Hotline is 866-549-0004.

Documentation Requirements

All organizational providers are recipients of Federal funds and as such are required to prepare and maintain appropriate medical records on all clients receiving services in compliance with Title 9, Chapter 11 and 42 CFR guidelines. The provider is expected to meet all documentation requirements established by the MHP in the preparation of these medical records. This includes all providers of outpatient, case management, and crisis residential services. The MHP has the responsibility to prepare and maintain the Documentation and Uniform Clinical Record Manual (DUCRM), which outlines the MHP's requirements and standards in this area. The Quality Improvement Unit distributes copies of the MHP's most recent version of the DUCRM annually throughout the organizational provider system. A copy may also be obtained at anytime by contacting the County QI Unit (619) 584-5026 or County Medical Records (619) 692-5700, extension 3. The Management Information System Anasazi User Manual contains detailed and specific requirement for the most commonly used services. This information is made available at www.ubhonline.com/publicSector/ or can be found in Management Information Systems Anasazi User Manual Organizational Provider Operators Handbook Volume II.

Many of the requirements present in the MHP's DUCRM are derived from the contract to provide specialty mental health services between the California Department of Mental Health and San Diego County Health and Human Services, Exhibit A, Attachment 1, Appendix C "Documentation Standards for Client Records". A copy of this "Documentation Standards for Client Records" is contained in *Appendix B (A.B.1).* Other documentation requirements have been established by the MHP's Uniform Medical Record Committee, which is an ad hoc committee chaired by the Quality Improvement Unit.

In order to ensure that organizational providers are knowledgeable of documentation requirements, the Quality Improvement Unit provides the following on an ongoing basis:

- Annual in-service training for all provider program managers that reviews the most current edition of the DUCRM, highlighting modifications or additions to the manual;
- Quarterly in-service documentation trainings for all new clinical staff, or any clinical staff that may need a documentation review;
- In-service trainings that are provided on-site at program's request, tailored to program's specific documentation training needs; and
- In-service trainings provided on-site at a program when QI has identified a specific documentation training need.

Compliance in documentation requirements by all organizational and county providers is monitored on an annual basis via medical record reviews. A Quality Improvement Specialist performs the medical record reviews. The Quality Improvement Unit has the responsibility to track and monitor results of these medical record reviews, and may require a provider to develop

a Plan of Correction to address specific documentation requirements that are found to be out of compliance.

For more information about the San Diego County Compliance Office contact:

http://www.sdcounty.ca.gov/hhsa/programs/sd/compliance_office/privacy_and_security_information_notices.html

CONFIDENTIALITY

Providers and their agents will abide by applicable state and federal laws regarding confidentiality. Applicable law could include, but is not be limited to, 45 CFR 164 (HIPAA), CA Civil Code 56 (CMIA), 5 U.S.C. § 552a (the 1974 Privacy Act), U.S.C 38 §7332 (Veterans Benefits), CA W&I Code 10850.1 (Multiple Disciplinary Teams). The maintenance of client confidentiality is of primary importance, not only to meet legal mandates, but also because of the fundamental trust inherent in the services provided through the MHP.

MHP Responsibilities

In order to ensure compliance with confidentiality policies and protocols, the MHP (the MHP) enforces the following procedures:

- Every member of the workforce* is informed about confidentiality policies, as well as applicable State and Federal laws regarding patient anonymity and the confidentiality of clinical information.

- As a condition of employment, each member of the workforce signs a confidentiality agreement, promising to comply with all confidentiality protocols.

- Any client treatment records gathered during the course of case management, provider site and record reviews, or as necessary, are protected through strictly limited access. Internal clinical staff has access to case data and files only as necessary to perform their job.

* *Workforce is defined as employees, volunteers, trainees, and other persons whose conduct, in the performance of work for the provider, is under direct control of the provider, whether or not the individuals is paid by the provider*.

COMPLIANCE AND CONFIDENTIALITY

Provider Responsibilities

Each provider will act in accordance with good judgment, clinical and ethical standards and State and Federal law to ensure that all written and verbal communication regarding each client's treatment and clinical history is kept strictly confidential.

Every provider must have policies, procedures and systems in place to protect the confidentiality (or security) of health information and individual rights to privacy. Requirements include safeguards to prevent intentional or accidental misuse of protected health information and sanctions for employee violations of those requirements.

Each provider must train all members of its workforce on the policies and procedures with respect to protected health information. The provider must document that the training on confidentiality has been provided. At a minimum, documentation of training shall consist of a signed acknowledgement by the member of the workforce specifying which training has been received and the date the training was taken. The provider must retain the documentation of the training for six years. These training records will assist the provider in identifying where supplementary training needs to be conducted if there are changes in the privacy or security regulations.

Every provider must have in place a Confidentiality Agreement for all workforce members. The Confidentiality Agreement should sufficiently identify the type of information to be protected, the workforce's/vendor's responsibility to protect it, and methods that must be used to protect it in order to assure confidentiality and to comply with Health Insurance Portability and Accountability Act (HIPAA) regulations. The Agreement must include a signed statement from the workforce member/vendor saying that he or she has received the information related to the maintenance, disclosure, or destruction of confidential information. This statement must be signed within a reasonable period of time after the person joins the provider's workforce. Additionally, providers must be able also to access documentation showing that all vendors and business partner personnel with access to protected information have also signed such agreements with their employers.

Contractor and its agents and employees are subject to and shall comply with the Child Abuse Reporting Law (California Penal Code section 11164) and Adult Abuse Reporting Law (California Welfare and Institutions Code section 15630).

Providers must provide a written notice of information practices – "Notice of Privacy Practice" to all clients. Additionally, providers are to distribute the County Mental Health Plan (MHP) Notice of Privacy Practice to all new clients. A notation is made on the Assessment form (MHS-650 and/or MHS-663 and/or MHS 680) when the MHP-Health Plan NPP has been offered.

Providers should disclose to clients the fact that records may be reviewed in the course of supervision, case conferences, and quality management.

For further information regarding legal and ethical reporting mandates, please contact your agency's attorney, the State licensing board or your professional association.

Handling/Transporting Medical Record Documents Outside of Certified Clinics

To maintain the confidentiality of all client and family members and to maintain security of all medical records, all Mental Health Programs (County and contract) will transport medical records in accordance with a set of guidelines. Medical records must be maintained at a certified clinic site or an approved school site. When a medical document is completed at another service site, the document must be transported to the main program site as soon as possible but no later than 5 working days. The standard protocol for storing confidential materials shall be maintained until transport is possible, i.e. records kept in a locked cabinet.

When transport of the entire medical record is necessary, the following procedures shall be implemented:

- The entire medical record must be returned to the clinic or satellite the same day. No staff can keep the entire medical record overnight at a personal residence;
- The program director shall designate staff members who will be authorized to transport any medical records;
- The staff member shall inform the program director or designee when transport of a medical record is necessary;
- The medical record must be signed out and signed in by staff that will be transporting the record;
- Medical records shall be transported in a secured or locked portable file box or personal briefcase;
- While transporting, the records shall be secured in the vehicle;
- The staff person shall maintain the locked container with the medical records at all times until the transfer is completed;
- Under no circumstances are any records to be left unattended.

The staff person transporting the records is responsible for maintaining security and confidentiality of medical records at all times.

When transporting Identifying Client Data or Medical Record Forms such as progress notes or forms requiring signatures, no identifying information shall be put on these documents until which time said documents are secures in the client's medical record at the primary clinic where the record is being stored. Progress notes or other individual documents transported while in the field shall not contain the full name of the client. Only the initials of the client's name or the

client's case number will be put at the bottom of the form. When transferring the document into the medical record at the primary clinic site, the full name and case number of the client will be written on each page within three (3) working days.

A staff member may carry identifying client information only under the following limited circumstances.

1) The staff member is transporting medical records originated at another service site to the main program site where the record is housed (see paragraph 2 of this section).

2) The staff member is doing work outside the clinic site and must carry some client-identifying data from which to contact individuals/families while off site.

The staff member carrying identifying client data will ensure the maintenance of confidentiality by following these guidelines:

1) The confidential information will be with the staff member at all times. It will not be left unattended at any time or place. **This also refers to laptops which may contain client information.** Client information may be kept on an external drive (thumb drive) if appropriately secured.

2) Any client information, including telephone number, address or case number should not be linked to the fact that they are receiving mental health services.

3) The information will not at any time be left overnight in the car or car trunk of the staff member. It will be maintained in a secure container and taken with the staff member at all times.

4) Ideally, the information is kept in a locked compartment, such as a locked briefcase or boxed file. If this is not possible, the information is to be stored in a secure holder such as a three ring binder or accordion file which would not allow the information to be dropped. A manila folder is not adequate. All compartments or containers must be pre-approved for use by the program director.

In the event of a loss of a portion of a medical record or the MR, an incident report should be completed and sent to program monitor. Client, parent, or legally responsible adult shall be notified.

Privacy Breaches of Confidentiality

There are new state laws and regulations that went into effect January 1, 2009 regarding confidentiality breaches. Programs are required to be familiar with these new laws. In summary, SB541 adds or changes information on what to do if there are confidentiality breaches, including prompt reporting of privacy to CDPH, notification to patient no later than 5 days after the breach has been detected by the facility, and increased fines and penalties for privacy breaches. SB541 requires reporting of any "unlawful or unauthorized assess" to PHI. "Unauthorized" means *"the inappropriate access, review, or viewing of patient medical information without a direct need for medical diagnosis, treatment, or other lawful use as permitted by law"*.

In addition, under new federal regulations effective 9/17/09, Health Information Technology for Economic and Clinical Health Act (HITECH) will require notification to patients "without reasonable delay" but no later that 60 days after discovery, unless asked by law enforcement due to ongoing investigation. For larger breaches, see reporting requirements in addition to following all State and Federal laws and regulations, providers shall report to SDCMHS through the Serious Incident reporting process.

Privacy breaches commonly occur in the following ways:

1) Confidential materials being disposed of in non-secured trash receptacle
2) PHI left out on desks and computer screens
3) Laptops stolen when transported back and forth from work to home
4) Chart and other PHI carried outside the facility, then lost or stolen
5) Unlawful or unauthorized access to PHI (peeking issues)
6) Inappropriate verbal disclosures in and out of the workplace.

Claiming and Reimbursement of Mental Health Services

When providing reimbursable mental health services, providers are required to utilize all available payor sources appropriate for reimbursement of services. Many clients have one or more insurance sources (e.g., Medicare, indemnity, PPO, HMOs, Medi-Cal) and it is the responsibility each program to appropriately bill and collect reimbursement from primary and secondary insurance sources. For all clients receiving mental health services, programs are required to be aware of all available payor sources, be able to verify eligibility and covered benefits, obtain an Assignment of Benefits (AOB), track and process Explanation of Benefits (EOBs) and primary insurance denials, in order to seek reimbursement from secondary payor sources. All billing and submission of claims for reimbursement must be in accordance with all applicable County, State and Federal regulations.

For detailed guidelines and procedures regarding insurance billing, claims processing, assignment of benefits, determining eligibility, and accounts collection and adjustment, please refer to the **Financial Eligibility and Billing Procedures** in Volume II of this manual.

Coding and Billing Requirements

The Federal Health Insurance Portability and Accountability Act (HIPAA) includes requirements regarding transactions and code sets to be used in recording services and claiming revenue. The rule, contained in CFR Chapter 42, took effect in October 2003 and includes a requirement for both standard Procedure Codes and Diagnosis Codes. Uniform Medical Record forms (see Section G, Quality Improvement) of this Manual reflect the required codes, and County QI staff

regularly provides training on the use of the Service Record forms. Additional requirements for medical records come from the County's contract with the California Department of Mental Health; these requirements determine the nature of chart reviews during a Medi-Cal audit and the items for which financial recoupment of payment for services will be made by State or County reviewers. Following are current requirements and resources related to coding and billing:

- Services must be coded in compliance with the Management Information System Anasazi User Manual, Organization Provider Operations Handbook Volume II.
- Diagnoses must be coded using the International Classification of Diseases (ICD-9 CM, or ICD-10 when adopted). In general, a diagnosis is made using the fuller descriptions of the Diagnostic and Statistical Manual, 4th Edition, Text Revision (DSM-IV TR) and "crosswalked" to the correct service code for the Management Information System software (currently Ansazi) by the clinician. The service code should result in the highest level of specificity in recording the diagnosis.
- Services are recorded on the Service Record, which includes the Anasazi Service Code and the staff number. The Service Record is used to enter services to the MIS and will reflect the range of services actually in the provider's budget.

FALSE CLAIMS ACT

All HHSA employees, contractors and subcontractors are required to report any suspected inappropriate activity. Suspected inappropriate activities include but are not limited to acts, omissions or procedures that may be in violation of health care laws, regulations, or HHSA procedures. The following are examples of health care fraud:

- Billing for services not rendered or goods not provided.
- Falsifying certificates of medical necessity and billing for services not medically necessary.
- Billing separately for services that should be a single service.
- Falsifying treatment plans or medical records to maximize payments.
- Failing to report overpayments or credit balances.
- Duplicate billing.
- Unlawfully giving health care providers, such as physicians, inducements in exchange for referral services.

Any indication that any one of these activities is occurring should be reported immediately to the compliance officer:

Robert Borntrager
HHSA Compliance Officer
619.515.4246
Compliance.HHSA@sdcounty.ca.gov

HHSA employees, contractors and subcontractors may also use the HHSA **Compliance hotline** at **(866) 549-0004** to request information or report suspected inappropriate activities. This line provides direction to the caller or the option to remain anonymous.

The Federal False Claims Act

The Federal False Claims Act ("FCA") helps the federal government combat fraud and recover losses resulting from fraud in federal programs, purchases, or contracts. 31 U.S.C. §§ 3729-3733.

Actions that violate the FCA include:

- Knowingly submitting (or causing to be submitted) a false claim to the U.S. Government for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved by the Government;
- Conspiring to get a false claim allowed or paid by the Government;
- Delivering (or causing to be delivered) less property than the amount of the receipt, where the person with possession or control of the Government money or property intends to deceive the agency or conceal the property;
- Making or delivering a receipt without completely knowing that the receipt is true, where the person authorized to make or deliver the receipt intends to defraud the Government;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from an officer or employee of the Government or a member of the Armed Forces who has no legal right to sell or pledge the property; or
- Knowingly making or using a false record to conceal, avoid, or decrease an obligation to pay money or transmit property to the Government.

"Knowing" and "Knowingly" means a person:

- Has actual knowledge of the information;
- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. No proof of specific intent to defraud is required.

"Claim" includes any request or demand for money or property (including those made under contract) to the Government or to a contractor, grantee, or other recipient, if any portion of the requested money or property is funded by or will be reimbursed by the Government.

A person or organization may be liable for:

- A civil penalty $5,500 to $11,000 for each false claim;
- Three times the amount of damages sustained by the Government due to the violations; and
- The costs of a civil suit for recovery penalties or damages.

If a *qui tam* plaintiff alleges a false claims violation, the complaint and a written disclosure of the evidence and information that the person possesses must be served on the Government. Once the

action is filed, no person other than the Government is allowed to intervene or file a lawsuit based on the same facts.

Whistleblower Protection
An employee who has been discharged, demoted, suspended, threatened, harassed, or in any way discriminated against by his or her employer because of involvement in a false claims disclosure is entitled to all relief necessary to make the employee whole, including:

- Reinstatement with the same seniority status that the employee would have had but for the discrimination;
- Two times the amount of back pay plus interest; and
- Compensation for any special damage sustained because of the discrimination (including litigation costs and reasonable attorney's fees).

The protected false claims activities include investigation for, initiation of, testimony for, or assistance in a false claims action that has been or will be filed. An employee is entitled to bring an action in the district court for such relief.

The California False Claims Act

The California False Claims Act ("CFCA") applies to fraud involving state, city, county or other local government funds. The CFCA encourages voluntary disclosure of fraudulent activities by rewarding individuals who report fraud and allowing courts to waive penalties for organizations that voluntarily disclose false claims. Cal. Gov't Code §§ 12650-12655.

Actions that violate the CFCA include:

- Knowingly submitting (or causing to be submitted) a false claim for payment or approval;
- Knowingly making or using (or causing to be made or used) a false record or statement to get a false claim paid or approved;
- Conspiring to get a false claim allowed or paid by the state or by any political subdivision;
- Benefiting from an inadvertent submission of a false claim, subsequently discovering the falsity of the claim, and failing to disclose to the state or political subdivision within a reasonable time after discovery;
- Delivering less property than the amount of the receipt, where the person has possession or control of public property;
- Knowingly making or delivering a false receipt, where the person is authorized to deliver a document;
- Knowingly buying or receiving (as a pledge of an obligation or debt) public property from any person who has no legal right to sell or pledge the property; or
- Knowingly making or using a record to conceal, avoid, or decrease an obligation to pay money or transmit property to the state or local government.

<u>"Knowingly" means the person or organization:</u>

- Has actual knowledge of the information;

- Acts in deliberate ignorance of the truth or falsity of the information; or
- Acts in reckless disregard of the truth or falsity of the information. Proof of specific intent to defraud is not required.

"Claim" includes any request for money, property, or services made to the state or any political subdivision (or to any contractor, grantee, or other recipient), where any portion of the money, property, or services requested was funded by the state or any political subdivision.

The maximum civil penalty is $10,000, per claim. Persons who violate the CFCA may be liable to the state for three times the amount of damages that the state sustains because of the violation. The court can waive penalties and reduce damages for CFCA violations if the false claims are voluntarily disclosed. The CFCA does not apply to false claims of less than $500. Lawsuits must be filed within three years after the violation was discovered by the state or local official who is responsible for investigating the false claim (but no more than ten years after the violation was committed).

Liability to the State or Political Subdivision

A person or organization will be liable to the state or political subdivision for:

- Three times the amount of damages that the state or local government sustains because of the false claims violations;
- The costs of a civil suit for recovery of damages; and
- A civil penalty of up to $10,000 for each false claim.

Whistleblower Protection

Employers are prohibited from:

- Making or enforcing any type of rule or policy that prevents an employee from disclosing information to a government or law enforcement agency, or from investigating, initiating, testifying, or otherwise assisting in a false claims action; or
- Discharging, demoting, suspending, threatening, harassing, denying promotion to, or in any other manner discriminating against an employee because of his or her involvement in a false claims action.

If you have any questions about the HHSA Compliance Program or the Federal or State False Claims Acts please contact:

- **Bob Borntrager, CHC Compliance Officer at 619.515.4244 or by e-mail at: Compliance.HHSA@sdcounty.ca.gov**

C. ACCESSING SERVICES

Consistent with the Health and Human Services Agency's "No Wrong Door" policy, clients may access mental health services through multiple points of entry. Clients may call the Access and Crisis Line (ACL), call or walk into an organizational provider's program directly, or walk into a County-operated program.

In accordance with Title 9, California Code of Regulations requirements, organizational providers and County-operated clinics must maintain logs of all persons requesting Specialty Mental Health Services. Required information includes the date of inquiry, client's name, nature and degree of urgency of the request, and disposition of request. A sample copy of a Request for Services Log is located in *Appendix C(A.C.1)*.

Emergency Psychiatric Condition

Title 9 defines an "Emergency Psychiatric Condition" as a condition in which the client, due to a mental disorder, is an imminent danger to self or others or is immediately unable to provide for or utilize food, shelter or clothing. This situation indicates an immediate need for psychiatric inpatient hospitalization or psychiatric health facility services.

QI Goal for Services: Face-to-face clinical contact within one (1) hour of initial client contact/ referral.

Urgent Psychiatric Condition

Title 9 defines an "Urgent Psychiatric Condition" as a condition, which without timely intervention, is certain to result in an immediate emergency psychiatric condition.

QI Goal for Services: Face-to-face clinical contact within seventy-two (72) hours of initial client contact/referral.

Routine Condition

A "Routine Condition" is defined as a relatively stable condition and there is a need for an initial assessment for Specialty Mental Health Services.

QI Goal for Services: System wide average of eight (8) calendar days from initial contact to mental health assessment. This number is a system wide weighted average for all adult providers. Each year, providers are given a specific benchmark goal for wait times for their individual program based on past performance and QI goal for the current fiscal year. If you do not know your current benchmark, please contact the QI unit.

ACCESS AND CRISIS LINE: 1-800-479-3339

United Behavioral Health (UBH) operates the statewide San Diego County Access and Crisis Line (ACL) on behalf of the San Diego County Mental Health Plan (MHP). The ACL, which is staffed by licensed and master's level counselors, provides telephone crisis intervention, suicide prevention services, and mental health information and referral 24 hours a day, seven days a week. The ACL may be the client or the family's initial access point into the MHP for routine, urgent or emergency situations.

All ACL staff is trained in crisis intervention, with client safety as the primary concern. Staff evaluates the degree of immediate danger and determines the most appropriate intervention (e.g., immediate transportation to an appropriate treatment facility for evaluation, or notification of Child or Adult Protective Services or law enforcement in a dangerous situation). In an emergency situation, ACL staff makes direct contact with an appropriate emergency services provider to request immediate evaluation and/or admission for the client at risk. The ACL staff makes a follow-up call to that provider to ensure that the client was evaluated and that appropriate crisis services were provided.

If the client's condition is serious but does not warrant immediate admission to a facility, ACL staff performs a telephonic risk screening and contacts a provider directly to ensure that the provider is available to assess the client within 72 hours.

The ACL has Spanish-speaking counselors on staff. Other language needs are met through the Language Line, which provides telephonic interpreter services for approximately 140 languages at the point of an initial ACL screening. Persons who have hearing impairment may contact the ACL via the TTY line at (619) 641-6992.

Authorizations for Mental Health Plan Services Provided by the ACL

- Outpatient mental health services delivered to Medi-Cal beneficiaries through the Fee-for-Service (FFS) Provider Network only. This is a network of contracted mental health professionals including psychiatrists, psychologists, licensed clinical social workers, and marriage family therapists.
- Acute Inpatient Mental Health Services

Note: Outpatient services provided through County-operated and contracted provider programs do not require authorization. Clients who first access services by calling or walking into an organizational provider site or a County-operated program do not require authorization from UBH.

ACCESSING SERVICES

The following section provides guidelines on making referrals to and receiving referrals from the ACL:

Referrals to the ACL

It is appropriate to refer individuals to the ACL for:

- Access to publicly-funded Specialty Mental Health Services
- Crisis intervention for emergent and urgent situations
- Referrals for routine mental health services
- Information about mental health and mental illness
- Referrals to community resources for vocational, financial, medical, and other concerns.

Providers should inform clients about the option of their directly using the Access and Crisis Line by calling 1-800-479-3339. Clients should be given clear directions on how to use the ACL.

Provider Interface with the ACL

- Use the ACL as an adjunct to provider services in emergencies and after hours. To provide the most effective emergency response and back-up to their own services, provider office voice mail messages should state, "If this is a mental health emergency or crisis, please contact the Access and Crisis Line at 1-800-479-3339."

- If a client is high risk and may be calling the ACL for additional support, the client's therapist or care coordinator may call (with client's approval) the ACL in advance on behalf of the client. (Please obtain a signed Release of Information from the client). To facilitate the most effective ACL response to the high-risk client's needs when he or she calls, please provide the ACL with all relevant clinical and demographic information.

Receiving Referrals from the ACL

The ACL considers multiple screening criteria when making referrals. Referrals take into consideration:

- Urgency of need
- Level of Care guidelines
- Type of treatment or services indicated
- Geographic location
- Cultural issues
- Any specific client requests, such as provider gender, language or ethnicity.

Hours of Service Availability

In accordance with 42 CFR, providers serving Medi-Cal clients must ensure service availability by offering hours of operation that are no less than the hours of operation offered to commercial clients. If the provider serves only Medi-Cal clients, the hours of service availability must be the same for fee-for-service and managed care clients. Providers are also expected to ensure that hours of operation are convenient to the area's cultural and linguistic minorities.

The MHP QI Unit will monitor availability of service hours at the annual Site Review. Problems with availability will be monitored through examination of the provider's Internal Problem Resolution/Transfer Log and the Grievance/Appeals Logs of the MHP contracted advocacy organizations.

Available Language Assistance

Provider staff encountering consumers whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs.

According to 42 CRF, clients shall be routinely asked, at the time of accessing services, about their needs for free language assistance. According to Title 9 and AMHS policy, providers must document the offer and whether linkage was made to interpreter service for clients requesting or needing translation services in threshold or other languages. AMHS policy prohibits the expectation that family members, including minor children will provide interpreter services; however, if clients choose to use family or friends, this choice also should be documented.

Interpreters can be qualified staff members at the provider site. Consistent with the AMHS Cultural Competency Standards, contractors are encouraged to develop and maintain staff's language competency for threshold languages. If no qualified staff is available, with the approval of the program manager or designee, program staff can contact Interpreters Unlimited (for language interpreting) at (800) 726-9891 or Deaf Community Services (DCS) (for hearing impairment) at (619) 398-2488 to arrange for free language assistance. If for some reason DCS is unable to provide for sign language services, providers may call Network Interpreting as a back up only at (800) 284-1043. If there is a need to use Network Interpreting, providers should document why DCS was not utilized. As soon as the services have been rendered, the provider will fill out a Service Authorization Form (*See Appendix C- A.C.2*).

The completed form will be faxed to Interpreters Unlimited or Deaf Community Services or Network Interpreting (back up only). The interpreting services will then submit an invoice to the MHP.

To comply with State and federal regulations, providers must be able to provide information on Mental Health Plan (MHP) services to persons with visual or hearing impairment, or other

disabilities, making every effort to accommodate an individual's preferred method of communication.

Client Selection of a Provider

In accordance with 42 CFR and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, hours of service, type of services offered, and areas of cultural and linguistic competence. Information about organizational providers is posted on the *Network of Care* website (www.networkofcare.org), and in the *Organizational Provider Resource Manual*, which may be obtained through the Mental Health Administrative staff by calling (619) 563-2788. Information on fee-for-service providers is available from UBH. When feasible, beneficiaries will be provided with the initial choice about the person who provides specialty mental health services, including the right to use culturally specific providers.

Note: Contractors shall report to the AMHS QI Unit any changes in location, hours or types of services offered to keep the Organizational Provider Resource Manual current. Providers will be surveyed periodically about cultural and linguistic capabilities.

Clients Who Must Transition to a New Provider

Many clients are unable to complete an entire treatment episode with the same therapist or mental health worker. This happens because of staff resignations, program closings, client change of residence or placement, transition of youths to the AMHS system, and completion of internships and field placements. The transition is likely to be difficult and disruptive to clients. Good clinical practice indicates that the following should be implemented whenever possible:

- The client and caregiver should be informed of the impending change as soon as it is clinically indicated and possible, but at least 14 days prior to the final visit with the first program.
- The client and caregiver should be informed of the client's right to request a new provider.
- Client and caregiver should be encouraged to voice their needs regarding provider clinical and language capabilities, time of appointment, location of the new clinic or program, transportation, etc.
- The client should be assisted in making a first appointment with the new program.
- The old and new program must communicate as completely as possible, via case consultations, phone conversations, and release of discharge summaries and other chart materials.
- A thorough discharge summary (or a transfer note, if the client will continue in the same program) should be written and incorporated into the chart.
- Final outcome tools should be administered if the client will go to another provider program.

- A plan for emergency services should be developed with the client and caregiver, to include the ACL, the new program, and informal supports.

ACCESSING SECURE FACILITY/LONG-TERM CARE (SF/LTC)

Locked/secure facilities service those residents of San Diego County who experience serious psychiatric disabilities and require a secure, safe, and structured environment; these residents are not entitled to services through other systems, either public or private.

Referral Process

United Behavioral Health (UBH), which provides mental health administrative services to the County of San Diego Mental Health Plan, provides Utilization Management for County-funded locked/secure facilities. Referring agencies shall submit an information packet to the United Behavioral Health (UBH) Long-Term Care (LTC) Coordinator. The packet shall include the following:

1. Referral form for a San Diego County-funded SF/LTC
2. Court Investigative Report for San Diego County LPS Conservatorship
3. Complete Psychiatric Assessment including psychiatric history, substance abuse history and history of self destructive or assaultive behavior, if applicable
4. Current Physical and Medical History
5. Current medications
6. One week of progress notes (including nursing group and medical doctor [MD])
7. Hospital face sheet
8. Proof of current Medi-Cal coverage (an Automated Eligibility Verification System [AEVS] strip from the hospital business office) or alternative funding for all ancillary services
9. Current completed Mini Mental Status Exam
10. Current lab reports
11. Result of purified protein derivative (PPD) (tuberculosis [TB] test) or clean chest x-ray from current hospitalization
12. Recommendation and information from the case manager, if possible

If the packet is not complete, the referral shall not be processed until all of the information is available.

The UBH Long-Term Care Coordinator shall review all referrals for completeness of information and eligibility for admittance. If the Coordinator has questions or concerns, he/she shall consult with the UBH Long-Term Care Medical Director. The San Diego County Long-Term Care Manager and/or the County Adult/Older Adult Mental Health Services Medical Director shall also be available for consultation. At times, even though the referral is complete, there may be concerns about whether the individual meets admittance criteria for SF/LTC. In these cases, the UBH LTC Medical Director or his/her designee may complete an independent on-site evaluation of the referred individual. The Secure Facility/Long-Term Care Placement Committee shall review the information when it is established that the referred individual meets the admittance requirements for SF/LTC.

Target Population

The persons served should have the potential to benefit functionally from psychiatric rehabilitation services and have the capacity to progress to a less restrictive level of care. The client must have an Axis I psychiatric diagnosis (as the primary diagnosis) and meet the Medi-Cal criteria for psychiatric inpatient services at the time of application. The person will have been certified as gravely disabled, despite active acute care interventions and will have a temporary or permanent conservator. The age range is from 18 through 64 years, although persons 65 and older may be admitted to treatment programs as an exception, if it is determined they can benefit from the program.

Eligibility Criteria for Admittance to SF/LTC

To County-Funded Secure Facilities/Long-Term Care

Individuals must meet all of the following criteria:

1. have met Title 9 medical necessity criteria for psychiatric inpatient services at time of referral.

2. be unable to be maintained at a less restrictive level of care.

3. have an adequately documented Axis I diagnosis of a serious, persistent, major**,** non-substance-abuse-related mental disorder as stated in Title 9. This diagnosis must not be primarily a manifestation of mental retardation or other developmental disorder. Clients may also have a concurrent diagnosis on Axis II or have a substance abuse diagnosis as a concurrent Axis I diagnosis. An Axis II diagnosis alone is not, however, sufficient to meet criteria.

4. have the potential to benefit from psychiatric rehabilitation services and potential to progress to a less restrictive level of care.

5. be gravely disabled as determined by a court's having established a temporary or permanent public or private San Diego County Lanterman-Petris-Short (LPS) Conservatorship. Grave disability is defined in the Welfare and Institutions Code 5008, Section (h)(1)(A)… "A condition in which a person, as a result of a mental disorder, is unable to provide for his or her basic needs for food, clothing, or shelter."

6. be a resident of San Diego County who is both indigent and referred by the San Diego County Psychiatric Hospital or who has San Diego Medi-Cal as his primary insurance or alternative funding for all ancillary services.

7. not be entitled to comparable services through other systems (i.e., Veterans Administration [VA], Regional Center, private disability insurance, Forensic system, etc.).

8. be 18 to 64 years old, although persons 65 and older may be admitted, as an exception, if it is determined that they can benefit from the program.

9. have absence of a severe medical condition requiring acute or complex medical care in accordance with applicable Skilled Nursing Facility/Special Treatment Program (SNF/STP) or Mental Health Rehabilitation Center (MHRC) regulations.

10. have current tuberculosis (TB) clearance.

11. be on a stable, clinically appropriate medication regimen.

12. have absence of chronic or recurrent dangerousness to self or others. This includes absence of chronic or recurrent episodes of assaultive behavior.

13. be an individual between the age of 18 and his/her 21st birthday and must also meet the following criterion:

    a. have been offered or considered for services by Therapeutic Behavior Services. A certification form shall be completed.

To Vista Knoll

San Diego County has a contract with Vista Knoll, a Skilled Nursing Facility in North County, in the specialized Neurobehavioral Health Unit for residents with Traumatic Brain Injuries (TBI). To be considered for admittance to these San Diego County-funded beds, individuals must meet all 13 criteria for admittance to County-funded secure facilities. In addition:

Individuals must have a current, adequately documented Axis I diagnosis of a serious, persistent, major, non-substance-abuse-related mental disorder as stated in Title 9, with evidence it existed prior to their Traumatic Brain Injury. Referral packets shall include complete documentation of this history.

To a State Psychiatric Hospital

Individuals must meet all of the following criteria:

1. Individual must meet all of the criteria for admission to a Secure Facility/Long-Term Care, with the exception of #12 above.

2. Be a current or recurrent danger to self or others, which includes chronic or recurrent episodes of assaultive or suicidal behavior**.**

3. All admissions to State Hospitals shall be approved by the County Adult/Older Adult Mental Health Services Medical Director.

4. Individual shall be on San Diego County LPS Permanent Public Conservatorship.

Reviews of Determination Decisions

Situations may arise in which the referring agency does not agree with the decision regarding admittance. The attending M.D., the conservator/client or the referring agency may request a review of the decision by notifying the San Diego County Adult/Older Adult Mental Health Director in writing within three business days. A copy of the request shall also be sent to the UBH Long-Term Care Coordinator and the County Long-Term Care Manager. This request shall include submission of the following information:

1. New detailed specific information as to why the individual meets the criteria for admittance.

2. Supportive documentation, as relevant.

The San Diego County Adult/Older Adult Mental Health Director or his/her designee shall review the information and may appoint a psychiatrist who has not had any previous involvement in the case as an independent reviewer. After review of the documentation, the San Diego County Adult/Older Adult Mental Health Director shall render the final determination regarding admittance.

Placement

For individuals who have been accepted into SF/LTC, the Secure Facility/Long-Term Care Placement Committee makes placement decisions.

Information about clients accepted for SF/LTC services is presented at a weekly Secure Facility/Long-Term Care Placement Committee meeting to determine optimal placement. In some cases, the most appropriate placement may not be clear. In these situations, more information may be requested from the referring agency or the case manager. In some cases, an on-site evaluation of the referred individual may be appropriate. The UBH LTC Coordinator is responsible for notifying the referral agency as to the outcome after the placement decision. At times, placement in a County-funded, out-of-County located program may be appropriate. In these cases, the following criteria shall be met:

1. Individual meets all criteria for in-County placement;
2. Individual has been refused placement by all in-County facilities, or there are compelling clinical reasons (e.g., deaf program) established that the individual would benefit from out-of-County placement;
3. The San Diego County Long-Term Care Manager has approved the placement; and
4. Certification has been obtained from the Assistant Deputy Mental Health Director that funding is available for placement.

Placement in a State Hospital

When a client has been approved for admittance to a State Hospital by the San Diego County Adult/Older Adult Mental Health Services Medical Director, and the State Hospital has accepted the client, the County Case Manager/Conservatorship designee shall ensure that all legal documents and paperwork are in order enabling transportation and admittance to a State Hospital. Certification must be obtained from the appropriate Assistant Deputy Director that funds are available to support the placement. In addition**,** the County Case Manager/Conservatorship designee shall notify the facility and the UBH LTC Coordinator of the discharge and transportation date and time. The referring facility shall have the client and the client's belongings ready to be transported.

Services to Undocumented Clients

In accord with County and State policy, the Uniform Method of Determining Ability to Pay (UMDAP) does not require that a person have a specific period of residence in the county or state to qualify for services. Intent to reside in San Diego County is a necessary condition, and is established by the client's verbal declaration. This applies to foreign nationals, including undocumented immigrants. Without intent to reside in San Diego County, any client, regardless

of citizenship, must be billed at full cost. However, persons known to be undocumented immigrants are eligible only for emergency services, such as an acute care hospital or the EPU.

Mental Health Services to Undocumented Adult AB 2726 Students

Immigration status has been concluded to play no role in determining whether a school district is responsible for educating a student. Therefore, immigration status shall not be taken into consideration for students between 18 and 22 years of age who are still participating in a high school program and require mental health services pursuant to their Individualized Education Plan (IEP). Undocumented adult Assembly Bill 2726 students shall receive appropriate mental health services as outlined in their IEP.

D. PROVIDING SPECIALTY MENTAL HEALTH SERVICES

Coordination of Care: Creating a Seamless System of Care

Coordination of care among inpatient and outpatient service providers is essential for a mental health system to work efficiently. As the client may move between different levels of care, it is vital that service providers communicate with each other to provide continuity of care for the client. This also supports the clients' efforts to return to, achieve and maintain the highest possible level of stability and independence. The MHP Systems of Care stipulates that the provider shall provide each client with a care coordinator as the "single point of accountability" for his or her rehabilitation and recovery planning, and service and resource coordination. The MHP monitors coordination of care.

For additional related information, review System Redesign Implementation Plan for Adult/Older Adult Mental Health Services, August 1999; and HHSA, MHS Policy and Procedure: Coordination of Care and Services No: 01-06-60. These resources are available by contacting your Program Monitor.

72-Hour Post Discharge Coordination of Care

Any new or current client who meets the criteria for needing "urgent" services shall been seen within 72 hours. A need for urgent services is defined in Title 9 as a condition, which without timely intervention is certain to result in a person being suicidal, homicidal or gravely disabled, and in need of emergency inpatient services. Any person being discharged from a crisis residential facility, a psychiatric hospital, jail, the EPU or a locked/IMD placement who is screened as needing services urgently shall be seen with 72 hours. In addition any other new or current clients who call for services and are screened as needing services urgently also meets the "urgent" criteria and shall be seen with 72 hours. To assist with tracking of admissions for existing clients, providers are expected to check the Morning Reports that can be generated each day. Providers are expected to track client discharge referrals and follow-up appointments. A sample of a 72-Hour Post Discharge Log is located in *Appendix D (A.D.1).*

Monitoring Coordination of Care

Inpatient medical record reviews include retrospective review of documentation to confirm that clients were referred to an outpatient program, psychiatrist or other licensed mental health care provider upon discharge. Outpatient reviews include review of chart documentation and the 72-Hour Post Discharge Log to verify outpatient appointments within 72 hours of discharge.

Outpatient Services

The MHP defines adult clients as those between the ages of 18-59 years. Older adults are age 60

and above. Clients may access services through organizational providers and County-operated facilities in the following ways:

- Calling the organizational provider or County-operated program directly
- Walking into an organizational provider or County-operated program directly
- Calling the Access and Crisis Line at 1-800-479-3339

When the provider conducts an assessment of a client who has called or walked into the program, that provider is responsible for entering administrative and clinical information into all the appropriate fields in Anasazi. Providers must complete the demographic and diagnosis fields and open an Assignment in Anasazi. See the Management Information Systems Anasazi User Manual, Organizational Provider Operations Handbook, Volume II for a description of how Anasazi supports these provider activities.

If the Access and Crisis Line refers a client to an organizational provider or to a County-operated facility, the ACL opens a record in Anasazi for each client. The provider's program staff is then responsible for recording all ongoing activity for that client into Anasazi.

Medical Necessity for Outpatient Services

Title 9 (Section 1830.205) Medical Necessity criteria are summarized below. (A complete description of Medical Necessity Criteria has been included in *Appendix D – A.D.2*.)

Note: For a hard copy of Title 9, please call the State Office of Administrative Law at 916-323-6225.

Services provided to clients by outpatient providers are reimbursed if the following medical necessity criteria are met:

1. The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for outpatient services as described in Title 9, Section 1830.205(1).
2. The client must have at least one of the following as a result of the mental disorder(s):
    - A significant impairment in an important area of life functioning; or
    - A probability of significant deterioration in an important area of life functioning.
3. All of the following:
    - The focus of proposed intervention is to address the significant impairment or probability of significant deterioration in an important area of life functioning;
    - The proposed intervention is expected to benefit the client by significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning; and
    - The condition would not be responsive to physical health care treatment.

SPECIFIC PROCEDURES AND CRITERIA FOR OUTPATIENT CARE

Clarification of Service Mix for Programs

On May 24, 2006, a special meeting was held with providers to discuss certain issues pertaining to Short-Doyle/Medi-Cal and other health coverage, including Medicare. Attendees were provided with clarification on what San Diego County Adult/Older Adult Mental Health System's expectations are for service mix of its organizational provider programs effective July 1, 2006. The following is the information that was presented:

- Case Management (CM) programs are only authorized to provide case management brokerage, individual and group rehabilitation, collateral, and occasional crisis intervention services.
    - Note that the evaluation completed when a client enters a case management program is designed to determine case management and rehabilitation needs and should be coded as a Rehab Evaluation.
- Assertive Community Treatment (ACT) programs are authorized to provide primarily case management brokerage and individual and group rehabilitation, collateral and occasional crisis intervention services.
    - ACT programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity, medication support services and some psychotherapy.
- Outpatient Biopsychosocial Rehabilitation Programs (OP/BPSR) are authorized to provide primarily individual and group rehabilitation, collateral, medication support, case management brokerage and occasional crisis intervention services.
    - OP/BPSR programs are also authorized to provide an initial clinical assessment for the purposes of determining medical necessity and some psychotherapy.
- Crisis Residential Programs are authorized to provide medication support services, and crisis residential services bundled as a 24-hour service.

Clinical Assessment for Medical Necessity

At the time a client is admitted to a program, clinicians shall perform a face-to-face assessment to ensure that each new client meets medical necessity criteria for specialty mental health services. According to service mix outlined above, the clinician shall complete the appropriate assessment form as indicated in the AMHS' Uniform Clinical Record Manual and ensure that all relevant clinical information is obtained and documented.

The following are specific procedures and criteria for each level of care:

Outpatient Providers

Within one month after the first planned visit, an Assessment and Client Plan shall be completed. If, after completing the assessment, the clinician determines that medical necessity criteria for specialty mental health services are not met, the client will be issued an NOA-A (see more complete description of the process in the Beneficiary Rights and Issue Resolution chapter of this Handbook) and his/her beneficiary rights shall be explained.

Case Management

Case Management services are services that assist a client to access needed medical, educational, social, prevocational, vocational, and rehabilitative or other community services. The service activities may include, but are not limited to, communication, coordination, and referral; monitoring services delivery to ensure beneficiary access to services and the services delivery system, monitoring of the clients progress, and plan development.

Prior to admission to the program, each client must have a face-to-face assessment to establish medical necessity and to determine the presence of serious psychiatric disability and need for case management services. If the clinician determines that medical necessity criteria is not met and the client is not continuing to receive other Medi-Cal specialty mental health services, the client will be issued an NOA-A and their beneficiary rights shall be explained. If medical necessity criteria is met but the person is deemed not in need of case management services, an NOA-A is necessary only if the person is not receiving other Medi-Cal specialty mental health services. Due to limited resources, case management eligibility is prioritized for those persons who have the most severe psychiatric disabilities. Level of case management service intensity will be determined on an individual basis, with usual prioritization of the most intensive case management services established for those persons who have had the highest levels of Medi-Cal hospitalization and/or the most extensive amount of locked long-term care. Within one month of the client's first planned visit, the Client Plan shall be completed.

OUTPATIENT CASE MANAGEMENT PROGRAMS

Case Management Service Eligibility

Due to limited resources, case management eligibility is prioritized for those persons who have the most severe psychiatric disabilities. Most clients who receive case management services are Medi-Cal beneficiaries. However, case management services may also be provided to individuals who meet the clinical criteria and are indigent or otherwise unable to access case management services. Level of case management service intensity is determined on an individual basis, with prioritization of the most intensive case management services for those

persons who have had the highest utilization of hospitalization and/or locked long-term care.
All case management clients must meet Title 9, Article 2, Section 1830.205 medical necessity requirements for outpatient mental health services and have major impairment in at least one area of life functioning. In addition, the person must demonstrate particular need for the additional services provided by case management services through one or more of the following:

- Has current LPS Conservatorship (may be a designated County Conservator or family member);
- Has been hospitalized or received involuntary psychiatric treatment within the past year;
- Is at high risk of admission to an inpatient mental health facility;
- Has a substantial need for supportive services (including care coordination and outreach mental health services) to maintain current level of functioning in the community, as evidenced by missed appointments, medication non-adherence, or inability to coordinate services from multiple agencies;
- Does not have a case manager from another program who is able to address mental health needs.

Clients receiving case management services are reviewed by the program's Utilization Review Committee (URC) to determine continuation of case management services and/or changes in the same level of case management.

Levels of Case Management

Three levels of case management services are available: Intensive, Traditional and Institutional.

- ***Intensive Case Management (ICM)*** programs provide a high level of mental health, rehabilitation and case management services, and have a staff to client ratio of approximately 1:10-15. Services, offered on a '24/7' basis, are delivered frequently and include a wide range of direct services. For example, ACT programs usually provide all medication management services to their clients.

- ***Traditional Case Management*** services provide a mix of mental health, rehabilitation and case management functions and have a staff-to-client ratio of approximately 1:35. Clients are evaluated in person at least monthly or by phone as clinically indicated, and it is expected that the case manager will have contact with significant others at least monthly. Services may be provided on a much more frequent basis, depending on client need.

- ***Institutional Case Management*** services are provided to clients who reside in the State Hospital, or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF). Services consist primarily of linking, coordinating and monitoring functions and have a staff-to-client ratio of up to 1:100. Clients are contacted

at least quarterly.

Referral Process for Case Management

Case management programs may receive referral information from any source. The program receiving the referral may determine that it is best able to serve the person, and will open the case. If the program receiving the referral determines the person might be better served through another provider, contact is made with the other program and the referral is forwarded for review. Each program maintains a log of all referrals and referral dispositions.

To align the demand for case management services with the capacity of case management programs and to assure connection with the program most relevant to the client's needs, referrals may be reviewed through the monthly Case Management Utilization Management Committee (CMUMC). Referrals among programs recommending transfer of a client (e.g., client has moved, client needs more or less intensive services than the program provides) may also be reviewed at this meeting.

Augmented Services Program

Designated case management services may refer to Augmented Services Program (ASP). The goal of the Augmented Services Program is to enhance and improve client functioning through augmentation of basic Board and Care (B&C) services to specific individuals living in specific residential care facilities with which the county has an ASP contract. Emphasis is on developing client strengths, symptom management, and client self-sufficiency. Priority for ASP services is given to those persons in most need of additional services. Additional information about ASP may be found in the ASP Handbook, which is provided to all designated case management services eligible to refer to ASP.

In order to be eligible for funding from ASP, a client must:

- Have a DSM-IV-TR Axis I or Axis II primary diagnosis of a serious mental disorder;
- Have an active case open to A/OAMHS case management program and have been evaluated by their care coordinator to be in need of ongoing case management services. The assigned case manager is the only person who can submit a request for ASP services;
- Reside in an ASP contracted facility;
- Score in the eligible range on the ASP scoring tool; and
- ASP funds must be available for the month(s) of service.

The client's case must remain open to the A/OAMHS program that provides ongoing monitoring, care coordination and case management services in order for the ASP facility to continue receiving ASP funds for the client. The case manager notifies the ASP and the ASP facility prior to the time that the case management program closes a client's case.

Inpatient Services for Medi-Cal Beneficiaries

Pre-Authorization Through OptumHealth

Inpatient service providers must secure pre-authorization for all inpatient services for Adults/Older Adults through the OptumHealth Provider Line, 1-800-798-2254, option #2, except:

- Emergencies/Urgent Services
- Clients directed by the San Diego County Psychiatric Hospital Emergency Psychiatric Unit (EPU) to the FFS Hospitals
- Intoxicated clients who will be assessed within 24 hours to determine the etiology of their symptomatology
- Medicare clients who convert to Medi-Cal on the Medi-Cal eligible date.

Medical Necessity for Adult/Older Adult Inpatient Services

Adult/Older Adult inpatient services are reimbursed by the MHP only when the following criteria are met, as outlined in Title 9, Section 1820.205.

- The client must have a diagnosis included in the Diagnostic and Statistical Manual, Fourth Edition (DSM IV-TR) that is reimbursable for inpatient services as described in Title 9, Section 1830.205(1).

AND

Both of the following:

- The condition cannot be safely treated at a lower level of care;
- Psychiatric inpatient hospital services are required as a result of a mental disorder and the associated impairments listed in 1 or 2 below:

1. The symptoms or behaviors:
   a. Represent a current danger to self or others, or significant property destruction;
   b. Prevent the beneficiary from providing for, or utilizing, food, clothing or shelter;
   c. Present a severe risk to the beneficiary's physical health;
   d. Represent a recent, significant deterioration in ability to function.

OR

2. The symptoms or behaviors require one of the following:
   a. Further psychiatric evaluation; or
   b. Medication treatment; or
   c. Other treatment that can reasonably be provided only if the patient is hospitalized.

Inpatient Services for Non-Medi-Cal Eligible Clients (Non-insured)

Clients without Medi-Cal eligibility or the means or resources to pay for inpatient services are eligible for realignment-funded services and are referred to the San Diego County Psychiatric Hospital or to the Emergency Psychiatric Unit for screening. Both facilities are located at 3853 Rosecrans Street, San Diego, California 92110. The telephone number is (619) 692-8200. These are County-operated facilities.

Crisis Residential Services

The MHP, through its contracted provider, operates Crisis Residential Services, which are considered a "step down" from inpatient services. Crisis residential services are provided to both Medi-Cal and non-Medi-Cal clients who meet medical necessity and admission criteria. Referrals for services can be made directly to the Crisis Residential intake staff and do not require pre-authorization from OptumHealth. More information about the locations and services provided by the Crisis Residential Programs may be obtained from the Network of Care website (www.networkofcare.org) or at the contractor's website, Community Research Foundation (www.comresearch.org).

Mental Health Services to Parolees

On a regular basis, individuals are discharged on parole from California State penal institutions (list of institutions located in *Appendix D – A.D.3*). In many instances, these persons are in need of mental health services. State law requires the California Department of Corrections to establish and maintain outpatient clinics that are designed to provide a broad range of mental health services for parolees. Sometimes, parolees are not aware of the availability of these services and present themselves to the County of San Diego Mental Health Services (MHS) outpatient clinics for their mental health needs. It shall be the responsibility of staff to ensure that all parolees from California State penal institutions who present for mental health services at a San Diego County program are appropriately served, or referred for service, in accordance with federal, State and County regulations as set out in the following guidelines:
Parolees who fall under the Forensic Conditional Release Program (CONREP) will be provided services in accordance with the current contract between the California Department of Mental Health and the County of San Diego.

1. Parolees who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.
2. Parolees with Medi-Cal coverage can receive inpatient services at any County-contracted acute care hospital. Indigent parolees can receive inpatient services at the San Diego Psychiatric Hospital.

3. Parolees who are Medi-Cal beneficiaries and who meet specialty mental health medical necessity requirements, as specified in CCR, Title 9, Section 1830.205, will be provided appropriate Medi-Cal covered mental health services.
4. Parolees, whether or not they are Medi-Cal beneficiaries, who do not meet specialty mental health medical necessity requirements will be referred for services at the local Department of Corrections-established outpatient mental health clinic, which is designed to meet the unique treatment needs of parolees, or to another health care provider.
5. Parolees who are not Medi-Cal beneficiaries and who do meet specialty mental health medical necessity requirements will be informed of the availability of services at the local Department of Corrections-established outpatient mental health clinic, and may choose to receive services from either County Mental Health or from the local Department of Corrections outpatient mental health clinic.
6. The California Welfare & Institutions Code, Section 5813.5 (f), explicitly prohibits the use of Mental Health Services Act (Proposition 63) funds for services to parolees. Managers of County and contracted programs which receive MHSA funding, are, therefore, responsible for ensuring that no MHSA funds are utilized for services to parolees from State prisons.

Mental Health Services to Veterans

Federal law has established the Department of Veterans Affairs (USDVA) to provide benefits to veterans of armed services. In 1996, the U.S. Congress passed the Veterans' Health Care Eligibility Reform Act, which created the Medical Benefits Package, a standardized, enhanced health benefits plan (including mental health services) available to all enrolled veterans. A prior military service record, however, does not automatically render a person eligible for these benefits. Only veterans who have established eligibility through the USDVA and have enrolled may receive them. In recognition of the fact that there are veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care providers, the legislature of the State of California in September 2005 passed AB599, which amended section 5600.3 of the California Welfare and Institutions Code (WIC). Specifically, veterans who are ineligible for federal services are now specifically listed as part of the target population to receive services under the mental health account of the local mental health trust fund ("realignment"). California veterans in need of mental health services who are not eligible for care by the USDVA or other federal health care provider and who meet the existing eligibility requirements of section 5600.3 of the WIC, shall be provided services to the extent resources are available. It shall be the responsibility of staff to ensure that all veterans who present for mental health services at a San Diego County program are appropriately assessed and assisted with accessing their eligible benefits provided through the USDVA or other federal health care program or are referred and provided services through a San Diego County program.

Referral Process for Providing Mental Health Services to Veterans

1. **Adult/Older Adult Mental Health Services:** Staff will ask client if he or she is receiving

veterans' services benefits. If the client states he or she is receiving benefits or claims to have serviced in the military, the staff will be responsible for completing the following procedure:

a. The staff will complete "Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form" *(located in Appendix D – A.D.4)* that will contain all appropriate demographic information and required client signature.

b. The form shall be faxed to the Veterans Service Office for verification at (619) 232-3960, or other current fax number.

c. If an urgent response is required, the mental health provider shall note on the Request Form in the Comment Section and contact the office by telephone after faxing the Request Form. All individuals who present for emergency mental health services shall be provided appropriate emergency assessment and crisis stabilization services, including processing for inpatient admission, if necessary.

d. If the client meets the eligibility criteria for seriously mentally ill persons and is receiving veteran benefits but needs mental health services not offered by the USDVA, the client can be offered mental health services.

e. If the client meets the eligibility criteria for seriously mentally ill persons and eligibility for veterans' services is pending, the client can be offered mental health services until the veterans services benefit determination is completed.

2. **Veterans Service Office:** The Veterans Service Office will receive the "Request for Verification Eligibility to Counseling and Guidance Services Fax Form" confirming client's eligibility or ineligibility for veterans' services and mail or fax findings to the County mental health program or contracted program.

a. The Veterans Service Office will respond to the Request for Verification of Veterans Eligibility for Counseling and Guidance Services Fax Form within two to three business days upon receipt of the Fax Request.

b. The Veterans Service Office will make referrals for benefit determination for an individual upon verification of eligibility status for veterans' services. The Veterans Service Office will also assist individuals in getting an appointment set up for evaluation of services if needed.

Utilization Management

The MHP delegated responsibility to County-operated and contracted organizational providers to perform utilization management for outpatient, crisis residential and case management services. Decisions are based on the medical necessity criteria delineated in Title 9 of the California Code of Regulations. The MHP monitors the utilization management activities of County-operated and contracted organizational providers to ensure compliance with all applicable State and federal regulations.

The Utilization Management for all service providers (outpatient, crisis residential, case management) includes procedures for establishing a Utilization Review Committee (URC),

standards for participation in the URC, logs for URC activities, and standards for authorization. Although there are slight variances in the utilization review process conducted by different service providers based on level of care, all programs participating in utilization review shall adhere to the following guidelines:

- Utilization review is a "not billable activity"
- URC logs are to be maintained at each program that record the results of the UR process
- URC logs are to be made available for review as needed by the MHP
- A clinician cannot participate in the authorization decisions regarding their own client
- Questions pertaining to the UR process should be directed to the Adult QI unit.

The Utilization Review procedures for Crisis Residential, Outpatient and Case Management programs are outlined below. All applicable forms and logs necessary to perform the Utilization Review process are located in *Appendix D (A.D.5 – A.D.12).*

Utilization Review for Crisis Residential Programs

Each crisis residential program, referred to as Short Term Acute Residential Treatment (START) program, shall convene a Utilization Review Committee (URC) to review all admitted clients in order to authorize services on an ongoing basis. The URC shall be multi-disciplinary and shall include, at a minimum, one licensed clinician designated by the Program Director to serve as the chair of the URC, as well as a minimum of two additional staff members who provide direct services or clinical oversight. Each URC shall meet 2-3 times per week, in conjunction with the START program's Treatment Coordination Committee (TCC) meeting. All clients will be reviewed by the program's URC within 3 days when possible, but no later than the 5th day after admission, in order to determine initial responsiveness to the services as well as set a projected length of stay and discharge date. Additionally, at a weekly minimum, all clients will be reviewed for ongoing medical necessity by the URC. Clients will be invited to attend the TCC/URC meeting when their treatment is being discussed. Should clients not want to attend the meeting with the URC members, staff will have input from the client prior to the meeting and will meet with the client again following the meeting in order to review the results. A "TCC/URC Record" *(located in Appendix D – A.D.6)* will be created for each client and filed in the front of the progress notes section of the client's medical record. Additionally, "URC Minutes" *(located in Appendix D – A.D.7)* will be maintained.

Utilization Review for Outpatient Programs

Beginning July 1, 2010 the MHP implemented a policy change affecting the Adult/Older Adult Mental Health Services (AOAMHS) utilization review process. The purpose of this new policy is to reinforce a change of the primary focus of current County Mental Health-funded (AOAMHS) outpatient clinic practices to recovery-oriented brief treatment and establish the requirement for implementing the Utilization Management process. In connection with this

policy, clients who still require services but who are stabilized and able to function safely without formal County Mental Health outpatient services will be referred to a primary care setting or other community resources for services. It is the expectation of AOAMHS that most clients shall receive brief treatment services that focus on the most critical issues identified by the clinician and client and that services will conclude when clients are stabilized.

Outpatient Guidelines:

I. Brief Solution-Focused Outpatient Services

Outpatient clinic services that shall be targeted as brief or time-limited include brief solution-focused individual and/or group treatment, individual and/or group rehabilitative services, and medication management as appropriate for stable clients who may be referred elsewhere for services. Services that may be delivered include:

- Clinical triage
- Assessment
- Possibility of up to 12 Therapy/Rehabilitative Sessions, which may include individual therapy or rehabilitation but with an emphasis on group/rehabilitation treatment as indicated. The number of services noted above (up to 12) is a recommendation and not a maximum number of services allowable.
- Group therapy
- Case Management
- Medication support as indicated

Clients receiving services which are Evidence-Based may be exempted form the following Utilization Management process with consent form the Program or Contract Monitor.
Clients will receive appropriate support and services to ensure that transition to other services are successful.
Clients who are referred elsewhere for medication or psychology services may still access County Mental Health-funded case management, peer support, and clubhouse services.

II. Initial Eligibility for Services

Initial Eligibility for Urgent and Routine Services will be based on meeting the criteria for:

- Title 9 Mental Health Medical Necessity,
- The AOAMHS Target Population-

Individuals we will serve:

1. Individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment.
2. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and/or who require unusually complex medication regimens. Required psychosocial services may include illness management; or skill development to sustain housing social, vocational and educational goals.

Individuals we *may* serve, to the extent resources allow, but who otherwise may be referred to other medical providers, include:

1. Individuals with serious psychiatric illness that may be adequately addressed in a primary care practice, either by a primary care practitioner or an affiliated mental health professional within a primary care practice setting, when the acute symptoms do not place the individual at risk of danger to self or others, and do not threaten the individual's ability to sustain independent functioning and housing within the community.
2. Individuals with lesser psychiatric illness, such as adjustment reaction, anxiety and depressive symptoms that do not cause significant, functional impairment that could be addressed within the contest of a primary care setting or other community resources.

- A score on the **Milestones of Recovery Scale (MORS**) of 1-6

This criteria applies to all clients including Medi-Cal and indigent clients

III. Eligibility for Ongoing County or contracted Program Outpatient Services

To continue beyond limited brief sessions clients shall be reviewed through a Utilization Management process and meet the following three criteria

1. Continued Mental Health Medical Necessity, with proposed intervention/s significantly diminishing the impairment or preventing significant deterioration in an important area of life functioning.
2. Meet Target Population Criteria
3. MORS- rating guideline of 5 or less OR

   An approved justification or on-going services for clients with MORS of 6, 7, or 8 which includes at least one continuing current Risk Factor related to client's primary diagnosis:

   i. Client has been in Long-Term Care, had a psychiatric hospitalization, or was in a Crisis Residential facility in the last year.
   ii. Client has been a danger to self or to others in the last six months.
   iii. Client's impairment is so substantial and persistent that current living situation is in jeopardy or client is currently homeless.
   iv. Client's behavior interferes with client's ability to get care elsewhere.
   v. Client's psychiatric medication regimen is very complex.

IV. Utilization Management process:

In order to continue services, clients shall meet specific criteria and be reviewed through a Utilization management process which will be conducted internally at each program.

A. All clients will be reviewed for on-going services through the MORS Rating process

- A MORS rating will be completed on all client-medication only and medication plus, every three (3) months

B. Utilization Management is based on MORS rating:

- Clients with a MORS rating of 1 to 5 will be qualified to receive ongoing services at the county or contracted outpatient clinic.
  - The MORS rating shall be kept in the client record
  - No other requirements

- Clients with a MORS rating of 6 to 8 will be referred out of the county or contracted outpatient clinic for on-going services unless an exception is made (see process noted below)
  - The MORS rating shall be kept in the client record

- Exceptions for clients with a MORS rating of 6, 7 or 8
  - If a client receives a MORS rating of 6, 7, or 8 but the primary provider believes that the client should continue to receives services at the county or contracted outpatient clinic the primary provider shall complete the **Justification for On- going Services** (JOS) to continue sessions.

- For subsequent treatment, client must meet both of the following criteria.
  1. Continued Medical Necessity with demonstrated benefit from services
  2. Meet Target Population Criteria

- JOS shall be reviewed by program manager or designee
  - Program Manager or designee shall be licensed
  - Program Manager or designee may agree with primary provider or may recommend a different level of service.
  - Final determination shall be made after agreement by Program Manager or designee and primary provider.

- The JOS shall be kept in the client record.

- For clients with a MORS rating of 6, 7, or 8 the JOS process is to be completed every 3 months to determine continued eligibility for services. [Note that someone with a MORS rating of 8 should probably never be receiving services.]

C. Programs are required to have a Utilization Review Committee in place to review records at least quarterly of a minimum of 5 clients whose MORS scores are not improving.

i. For clients whose MORS score is not improving a review of services and treatment plan shall be completed
ii. Program may chose a minimum of clients to review but must review no less than 5
iii. Programs are required to use the Utilization Review Committee Form to document the results of the Utilization Review Committee. Attachment 2.
iv. QI may request a copy of the Utilization Review Committee Form be sent in to QI for monitoring purposes.

Other notable issues:

A. Clinicians shall clearly explain the process of services to clients upon intake.
B. Transition of existing clients: Effective 7/1/10, all current clients will be eligible for up to 12 brief individual therapy/rehabilitation sessions.
C. Clinicians shall clearly explain the process of services to clients upon intake. MORS shall be completed at admission and discharge and every 3 months.

Utilization Review for Case Management Programs

Each case management program shall convene a URC to review the provision of services on a concurrent basis. The URC shall decide issues of medical necessity, continuation of treatment and level of case management services. These decisions will be based on CCR, Title 9 Medical Necessity Criteria for diagnosis, impairment and interventions and Case Management Service Level Criteria. Decisions shall be supported by chart documentation of the client's individual functioning level, symptoms, and needs.

The URC shall consist of a minimum of three staff persons. The chair of the URC shall be a licensed/registered/waivered mental health clinician. Additional members shall be two or more staff who provides direct services or clinical oversight. A clinician shall not participate in the authorization decisions of his or her client. The QI unit may identify cases for review.

Initially, all clients who have been receiving case management services for more than two years shall be reviewed by the URC. The URC may only authorize up to one year of service at the same level. Conservatees do not have to be reviewed by the URC as they are reviewed annually by the Superior Court for continuing grave disability.

Prior to the utilization review of the client, the case manager will complete the *Six Month Review and Progress Note (located in Appendix D- A.D.11)* verifying that the client meets medical necessity and service necessity criteria. This will summarize necessary information in order to assist with the URC review. Case managers will prepare cases for URC review by the first of the month of their annual review when the admission date to the current program was two or more years ago. The Program Manager/Supervisor will develop a list of clients due for review each month and will notify the case manager and the URC of the cases to be reviewed. The URC will notify the program and case managers of the date and time of the URC and have the charts gathered accordingly.

A *Case Management URC Record (located in Appendix D- A.D.12)* shall be created for each client reviewed and filed in the front of the progress notes of the client's chart. This URC record will provide a summary of clinical information that supports the authorization decision. The *URC Minutes for Case Management (located in Appendix D – A.D.13)* shall summarize the outcomes of the cases reviewed. These minutes will be maintained in a designated file. The file shall be available for review as needed by the QI unit.

PROVIDING SPECIALTY MENTAL HEALTH SERVICES

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E. INTERFACE WITH PHYSICAL HEALTH CARE

Coordination with Primary Care Physicians

The bio-psychosocial model for recovery, practiced by County Adult Mental Health Services, recognizes the totality of the person and the important role of physical well being for progress toward recovery. For this reason, organizational providers are highly encouraged to coordinate beneficiary care, as needed, with San Diego's Medi-Cal Primary Care Physicians. Over 50% of Medi-Cal beneficiaries are enrolled in one of the seven Health Maintenance Organizations (HMOs) that are part of Healthy San Diego. The remaining Medi-Cal beneficiaries receive their physical health care from fee-for-service physicians. Organizational providers and County-operated programs are required by the MHP to request a Release of Information (ROI) from the client during the first visit to facilitate coordination with the client's Primary Care Physician, ensuring that confidentiality is maintained in accordance with applicable State and federal laws and regulations. Located in *Appendix E*, are the Healthy San Diego Physical and Mental Health Coordination Guidelines (A.E.1), Coordination Form (A.E.2), and an Authorization to Use or Disclose PHI Form (A.E.3), which providers may use to facilitate or enhance coordination of care with the client's Primary Care Physician.

Pharmacy and Lab Services

HMO Medi-Cal Beneficiaries

Each HMO has contracts with specific pharmacies and laboratories. Providers prescribing medication or lab tests need to be aware of which pharmacy or laboratory is associated with each client's HMO in order to refer the client to the appropriate pharmacy or lab. The client's HMO enrollment card may have a phone number that providers and clients can call in order to identify the contracted pharmacy or lab. Psychiatrists may order the following lab studies without obtaining authorization from the client's Primary Care Physician:

- CBC
- Liver function study
- Electrolytes
- BUN or Creatinine
- Thyroid panel
- Valproic acid
- Carbamazapine
- Tricyclic blood levels
- Lithium level

All other lab studies require authorization from the client's Primary Care Physician. It is recommended that each provider contact the client's HMO Member Services Department or

Primary Care Physician to determine which lab test(s) require authorization from the client's Primary Care Physician.

Medi-Cal Beneficiaries not Enrolled in an HMO

Medi-Cal beneficiaries who are not members of an HMO may use any pharmacy or lab that accepts Medi-Cal reimbursement.

Non-Insured Realignment Funded Clients

Realignment-funded (non-insured) clients may have their prescriptions filled at little or no cost at a County mental health clinic, or the Health and Human Services Agency Pharmacy at the Health Services Complex, 3851 Rosecrans Street, San Diego, California 92110.

Physical Health Services While in a Psychiatric Hospital

HMO Medi-Cal Beneficiaries

The client's Healthy San Diego HMO is responsible for the initial health history and physical assessment required for admission to a psychiatric inpatient hospital. The client's HMO also is responsible for any additional or ongoing medically necessary physical health consultations and treatments. The HMO contracted provider must perform these services, unless the facility obtains prior authorization from the HMO to use another provider.

The MHP contracted psychiatrist is responsible for obtaining the psychiatric history upon admission and for ordering routine laboratory services tests. If the psychiatrist identifies a physical health problem, he or she contacts the client's HMO to request an evaluation of the problem. If the psychiatrist determines further laboratory or other ancillary services are needed, the contracted hospital must obtain the necessary authorizations from the client's HMO.

Medi-Cal Beneficiaries not Enrolled in Healthy San Diego Health Plans

For those clients who are not members of a Healthy San Diego HMO, physical health services provided in a psychiatric hospital are reimbursed by Medi-Cal.

Medical Services for Non-Medi-Cal Eligible Clients (Non-insured)

The ACL may refer realignment-funded clients to County Medical Services (CMS) for assessments and medical services. The telephone number for CMS is (858) 492-4444.

Transfers from Psychiatric Hospital to Medical Hospital

Psychiatric hospitals may transfer a client to a medical hospital to address a client's medical problems. The psychiatric hospital must consult with appropriate HMO staff to arrange such a

transfer for physical health treatment. It is the responsibility of the HMO to pay for transportation in such cases. The UBH Medical Director and the HMO Medical Director will resolve any disputes regarding transfers.

Medical Transportation

Healthy San Diego HMOs will cover, at the Medi-Cal rate, all medically necessary emergency and non-emergency medical transportation services to access Medi-Cal covered mental health services. HMO members who call the ACL for medical transportation are referred to the Member Services Department of their HMO to arrange for such services.

Home Health Care

Beneficiaries who are members of one of the Healthy San Diego HMOs must request in-home mental health services from their Primary Care Physician. The HMO will cover, at the Medi-Cal rate, home health agency services prescribed by a Plan provider when medically necessary to meet the needs of homebound members in accordance with its Medi-Cal contract with the State DHS. The MHP will pay for services solely related to the included mental health diagnoses. The HMO case manager and the Primary Care Physician coordinate on-going, in-home treatment. The HMO is responsible for lab fees resulting from in-home mental health services provided to Medi-Cal members of the HMO.

Clinical Consultation and Training

Beneficiaries with less severe problems or who have been stabilized may be referred back to their Primary Care Physician for continuing treatment. To help support client's treatment by the Primary Care Physician, the MHP, as well as organizational providers and County-operated programs, should make clinical consultation, including consultation on medications, available to a beneficiary's Primary Care Physician. Clinical consultation, if requested, should also be made available for clients who are receiving treatment from a health care provider, in addition to receiving MHP services. These health care providers include Medi-Cal Managed Care Providers, Primary Care Providers not belonging to a Medi-Cal Managed Care Plan, to Federally Qualified Health Centers, Indian Health Centers or Rural Health Centers. As another means of supporting clients, Providers are encouraged to provide training to community partners, as requested, or as the need arises.

INTERFACE WITH PHYSICAL HEALTH CARE

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F. BENEFICIARY RIGHTS & ISSUE RESOLUTION

Client Rights and Protections Under Federal Code

According the Title 9 and 42 CFR 438.100, the MHP is responsible for ensuring compliance with consumer rights and protections. Providers, as contractors of the MHP, are also required to comply with all applicable regulations regarding consumer rights and protections. These rights and protections from 42 CFR can be summarized as follows:

- *Dignity, respect, and privacy*. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the managed care plan and available treatment options.* Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions.* Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.
- *Copy of medical records.* Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, Part 164.524 and 164.526.
- *Right to health care services.* Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.

In accordance with 42 CFR and Title 9, the MHP Quality Improvement Unit distributes the Guide to Medi-Cal Mental Health Services, which contains information on client rights, as well as a description of the services available through the MHP, and the avenues to obtain resolution of dissatisfaction with MHP services.

Note: *New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages of English, Spanish, Vietnamese, Arabic, and Tagalog.) Additional copies may be obtained from the MHP Strategic Planning and Administration Unit at (619) 563-2788.*

Additional Client Rights

- **Provider Selection**

  In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence. (See Section C - Accessing Services in this Handbook for details.)

- **Second Opinion**

  If the MHP or its designee determines that a client does not meet Title 9 Medical Necessity Criteria for inpatient or outpatient mental health services, a client may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care. As the MHP designee, UBH is responsible for informing the treating provider of the second opinion request and for arranging the second opinion with an MHP contracted individual provider.

  The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor/COTR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the MHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

- **Transfer from One Provider to Another**

  Clients have a right to request a transfer from one Medi-Cal provider to another within or outside of a program. These transfer requests shall be recorded on the Client Suggestions and Provider Transfer Request tab of the Monthly Status Report . Documentation in the Log shall include the date the transfer request was received, whether the request was to a provider within or outside of the program, and the relevant code showing the reason for transfer if specified by the client. The Log shall be submitted with the provider's Monthly Status Report.

- **Right to Language, Visual and Hearing Impairment Assistance**

  Clients shall be routinely informed about the availability of free language assistance at the time of accessing services. AMHS Policy prohibits the expectation that the client use family or friends for interpreter services. However, if the client so chooses, this choice

should be documented in the client record. For more complete information about linking clients to free interpreter services, please see the Accessing Services section of this Handbook.

Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and AMHS policy.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adult and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all new clients be given this information at their first face-to-face contact for services. An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to be in compliance with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.
3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.
5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. Copies may be obtained through the MHP Strategic Planning and Administration Unit at (619) 563-2788, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Clients' Rights

In accordance with DMH regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to Mental Health Services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Admission Checklist Form. Information on the Beneficiary Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented in the medical record. It is strongly recommended that this information be tied to the anniversary date of admission for services.

BENEFICIARY PROBLEM RESOLUTION PROCESS

San Diego County Mental Health Services is strongly committed to honoring the rights of every consumer to have access to a fair, impartial, effective process through which the consumer can seek resolution of a problem encountered in accessing or receiving quality mental health services. All contracted providers are required to participate fully in the Beneficiary Problem Resolution Process (Grievance and Appeal Process), which is located in its entirety in *Appendix F(A.F.1)*. Providers shall comply with all aspects of the Process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the Process. When a provider is notified by the contracted advocacy organization, the Consumer Center for Health Education and Advocacy (CCHEA) or JFS Patient Advocacy Program that a client has filed a grievance or appeal about that provider's program or staff, the provider shall cooperate with the investigation and resolution of the client's concerns in a timely manner as specified in the Process.

Consumers shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The consumer shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the consumer is not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

BENEFICIARY RIGHTS & ISSUE RESOLUTION

In accord with 42 CFR and Title 9, the County of San Diego Mental Health Beneficiary Problem Resolution Process has been streamlined, some terms redefined, and strict timelines added. An opportunity for provider appeals has also been added, as well as a clinical review of grievances and appeals concerning clinical issues. The provider continues to play an important part in this process as follows:

Problem Resolution at Provider Sites

In a continuation of past practice to most quickly and efficiently make providers aware of and resolve problems, clients are encouraged to direct their suggestions to program staff or management. This can be done orally or in writing. In attempting to reach resolution consistent with confidentiality requirements, staff or management shall utilize whatever information, resources and/or contacts the consumer agrees to. Provider will log all client reported problems in the Client Suggestions and Provider Transfer Request Log. In order to preserve client confidentiality, this log must be kept in a secure area. This log shall be submitted with the provider's Monthly Status Report.

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

At all times, Grievance and Appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place.

Grievance Process

Timeline: 60 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

A "grievance" has been defined as an expression of dissatisfaction about any matter other than an action. JFS Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within three (3) days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. In order to be in compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client's condition to review and make a decision about the case.

Appeal Process

Timeline: 45 days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

Appeals are reviews of actions by the MHP regarding provision of services through an authorization process, including:

- Reduction or limitation of services
- Reduction, suspension or termination of a previously authorized service
- Denial of, in whole or part, payment for services
- Failure to provide services in a timely manner.

See the Beneficiary Problem Resolution Process in *Appendix F (A.F.1)* for details. The Advocacy organization will contact the provider within three (3) working days of receiving the written permission to represent the client. Again, the provider's cooperation with the Advocacy organization to find a mutually agreeable solution is necessary to meet the strict mandated timelines in resolving the problem. The advocacy organization shall investigate the appealed matter and make a recommendation to the MHP. The MHP (Local Mental Health Director or designee) will review the recommendations of the advocacy organization and make a decision on the appealed matter.

Note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

Expedited Appeal Process

Timeline: Three (3) working days, with a possible 14-day extension for good cause.

When the standard appeal process could jeopardize a client's life, health or functioning, an expedited appeal may be filed for by the Advocacy organization, necessitating a very rapid turnaround from grievance to resolution. The advocacy organization will notify the provider as soon as possible, but in less than two (2) working days. The Mental Health Director will make a decision on the appeal on the third working day.

State Fair Hearings

Medi-Cal beneficiaries filing an appeal may request a State Fair Hearing, after using the County Beneficiary Problem Resolution Process whether or not they have received a Notice of Action

within 90 days after the completion of the Beneficiary Problem Resolution Process. State Fair Hearings are further discussed in the Beneficiary Problem Resolution Process in *Appendix F*.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Mental Health Director or designee in 10 days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Mental Health Director within 10 days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary Problem Resolution Process in *Appendix F* for details of this portion of the process.

Monitoring the Beneficiary Problem Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and service, will view feedback from the grievance/appeal process as a reflection of potential problems with service effectiveness and/or efficiency and as an opportunity for positive change. Information on problems may be incorporated into the ongoing contract monitoring and/or credentialing process.

CLIENT NOTIFICATION OF ACTION ON SERVICES (NOA PROCESS)

The State has developed the following forms to be used to notify clients about service provision:

Notice of Action-Assessment (NOA-A)

All Adult/Older Adult outpatient programs (County and contract), case management, short term acute residential treatment (START) programs, and the San Diego County Psychiatric Hospital (SDCPH) shall follow procedures for issuing NOA-A forms for Medi-Cal beneficiaries. In accordance with Title 9, Section 1850.210, an NOA-A shall be issued when services are requested and medical necessity criteria are not met and therefore no services are appropriate in the mental health system. Issuing of an NOA-A begins the 90-day period that a beneficiary has to file for a State Fair Hearing.

The NOA-A form informs the Medi-Cal beneficiary of the following:

- Reason for denial based on Title 9, California Code of Regulations
- Beneficiary's right to a second opinion
- The grievance/appeal process
- Right to a State Fair Hearing (once local process has been exhausted)

- Criteria for an expedited State Fair Hearing
- Explanation of the circumstances under which a specialty mental health service will be continued if a State Fair Hearing is requested
- Method by which a hearing may be obtained
- Beneficiary may be either self represented or represented by an authorized third party such as legal counsel, relative, friend or any other person.

The following procedures shall be followed by Adult/Older Adult County and Organizational providers when issuing an NOA-A:

1. The Notice of Action-Assessment (NOA-A) form shall be issued to a Medi-Cal beneficiary following a mental health screening and/or assessment (face to face or phone) when it is determined by the provider that the beneficiary does not meet medical necessity criteria, resulting in denial of all specialty mental health services.
    a. If upon screening/assessment, the beneficiary is identified as currently receiving specialty mental health services, an NOA-A shall not be issued.
    b. As part of the screening/assessment process, the beneficiary may be informed of the option to obtain care outside the Mental Health Plan. When a beneficiary verbalizes interest only in information gathering or in obtaining a referral outside of the Mental Health Plan (thus declining or modifying the original inquiry for specialty mental health services), no NOA-A needs to be issued. Services outside of the Mental Health Plan may not be reimbursable by Medi-Cal.
2. The NOA-A shall outline the action taken by the Mental Health Plan (MHP) or provider, reason for the action, beneficiary's rights, and citation of the specific regulations or MHP payment authorization procedures supporting the action.
3. In accordance with federal regulations, the NOA-A may be hand delivered on the date of the notice or deposited with the United States Postal Service in time for pick-up no later than three (3) working days of the decision by the provider.
4. All above cited programs shall maintain a Notice of Action Assessment Log on the program site.
5. The NOA-A Log shall document all NOA-As provided to Medi-Cal beneficiaries and their response to the NOA-A, if known.
6. The NOA-A Log shall contain the following information:
    a. Date the NOA-A was issued
    b. Beneficiary identification number, if known
    c. Response, including requests and provisions for second opinions, initiation of grievance/appeal procedure, and/or request for State Fair Hearing, if known.
7. The original NOA-A Log will be maintained at the program site, with a copy of each NOA-A issued attached. When no NOA-As are issued in a given month, the Log shall reflect this information with a check in the appropriate box. The Month Status Report shall identify the number of NOA-As issued during the report period.
8. When an NOA-A is issued, the Log shall be submitted with the provider's Monthly Status Report.

Notice of Action (NOA-B)

In response to a provider's request for continued treatment authorization, if the MHP or its designee should determine that a Medi-Cal client's treatment be denied or reduced, the provider and the client will receive an NOA-B form. The NOA-Back form describes the Medi-Cal client's right to file a grievance/appeal, and the right to a State Fair Hearing. Please review the NOA-B with the client and request that he/she sign the form, and return the signed NOA-B to the point of authorization.

If the Medi-Cal client chooses to exercise the right to file an appeal, or request a State Fair Hearing, the appropriate State office to contact is given on the NOA-Back form.

Note: A copy of the NOA-A, NOA-B and the NOA-Back forms are included in *Appendix F* (A.F.2, A.F.3, A.F.4) and may be copied.

Additional Types of Notices of Action

In response to 42 CFR, Notices of Action must be sent out for two additional reasons:

1. A Notice of Action form will be sent to a client from an advocacy organization (CCHEA or JFS Patient Advocacy) or the MHP, as appropriate, if a grievance, appeal, or expedited appeal is not completed in accordance with federal timelines. (NOA-D)

2. A Notice of Action form will be sent to a client from UBH if a Treatment Authorization Request (TAR) has been denied as a result of insufficient information submitted by the provider. (NOA-C)

It is expected that issuing these types of NOAs will be infrequent, but may result in clients approaching providers with a few questions. The State has provided the counties with specific forms for these new NOAs.

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G. QUALITY IMPROVEMENT PROGRAM

The MHP's philosophy is that high-quality mental health care is client centered, clinically effective, outcome driven, and culturally competent. The purpose of the MHP Quality Improvement Program is to ensure that all clients receive this type of mental health care. In order to achieve this goal, each provider in the system must have internal quality improvement controls and activities, in addition to those provided by the MHP. These activities may involve peer review, program manager monitoring of charts and billing activity, clinical outcome measurement, medication monitoring and/or a formal Quality Improvement unit, which offers training and technical assistance to clinical staff. In addition, all provider programs are required to attend regular Program Manager meetings, quarterly Leadership Plus meetings, QI In-Service and documentation trainings, and other training. These meetings are essential to keep abreast of system changes and requirements.

The quality of the MHP's care and service delivery system is ensured by continually evaluating important aspects of care and service, using reliable, consistent, and valid measurements, with the goal of maximizing each program's effectiveness. The basis of this evaluation process rests in State and Federal legislation and regulations including:

- 42 CFR, Code of Federal Regulations
- Title 9, Chapter 11, of the California Code of Regulations;
- State Department of Mental Health (DMH) Letters and Notices;
- the MHP Managed Care contract with the State DMH; and
- the Annual State DMH Protocol

The evaluation process is also being re-formulated and expanded to meet a number of new Federal regulations and legislative mandates including the following:

- Mental Health Services Act (MHSA)
- MHSA System Transformational Goals for the County of San Diego
- State mandated Performance Improvement Projects (PIP)---the State has mandated that each county undertake one administrative and one clinical improvement yearly.

Through program monitoring, program strengths and deficiencies are identified; educational and other approaches are utilized to achieve positive change. To be maximally effective, each provider's Quality Improvement Program must be a team effort. It requires the dedicated effort, responsibility, and involvement of clients, family members, clinicians, mental health advocates, and other stakeholders to share information on strengths and weaknesses of services.

Indicators of care and service, currently being evaluated, include, but are not limited to, client satisfaction, effectiveness of the service delivery system, performance and treatment outcomes, accessibility of services, cultural competency, adherence to health and safety standards, and preservation of client rights.

MEASURING CLIENT SATISFACTION

The MHP is committed to assessing client satisfaction with the quality of care and provision of mental health services. AMHS QI administers two State mandated client surveys annually to get this important feedback. The importance of provider participation in the survey process is critical to get an accurate picture of how well each provider and the mental health system as a whole are meeting client needs.

Mental Health Survey – State Requirement
Survey Period: *Two week period in Spring and Fall each year, as specified by the State DMH*

The State DMH selects a two-week time period twice a year in which all Outpatient providers, including Case Management, are required to administer the Mental Health survey. This survey consists of two parts, a MHSIP section which measures client satisfaction with services and Quality of Life section which measures client satisfaction with other aspects of daily living. This survey should be administered to **all** clients receiving services during the two weeks, **including clients receiving medications only.** UCSD Health Services Research Center (HSRC) is contracted by the MHP to handle the survey process. HSRC distributes the blank survey forms, collects the completed forms, and compiles provider and countywide satisfaction data. . Providers will be notified by HSRC of the exact State selected time period; historically, survey periods have been in May and November. The survey returns are scanned in to the State, therefore original printed forms provided by the MHP must be used. Because of the limited window for submitting this information to the State, providers are strongly requested to send in completed surveys according to HSRC instructions and immediately at the end of each survey period.

The criteria and guidelines for the Adult Survey are subject to change as determined by the County and State. Providers will be notified of changes affecting them.

MONITORING THE SERVICE DELIVERY SYSTEM

Using the Uniform Medical Record

All programs are required to utilize the forms specified in the San Diego County Adult Mental Health Services Documentation and Uniform Clinical Record Manual, and any updated forms, which are issued on an interim basis. Programs may adapt forms for specific program needs with the consent of the Uniform Medical Record Committee, which is an ad hoc committee chaired by the Quality Improvement Team. The Medical Record for each client must be maintained in a secure location, must be filed in the prescribed order, and must be retrievable for County, State, or federal audit upon request, during and after the provision of services up to the limits prescribed in California law.

Standards for "Late Entry" Documentation

All services provided to a client shall be documented into the client's medical record within a timely manner. Documentation should occur on the date the service was provided. If, however, this documentation does not occur on the date of service, the following shall apply:

- A "late entry" is defined as any documentation that is done on a calendar day other than the date the service was provided.
- When documenting a late entry in the client's medical record, "late entry" should be written at the beginning of the note.
- Late entry notes should be filed in the medical record chronologically to when written, not filed by the date the service was provided.

Claiming for a Late Entry

- Late entries will be accepted for claiming purposes up to 14 days after the date of service.
- If a late entry has not been documented within 14 days from the date of service, the service must still be documented but may not be claimed. The late entry would be considered a non-billable service and would be entered into Anasazi using service code 60.
- A recoupment will be made for a late entry with a documentation date of over 14 days from the date of service if this late entry has been claimed and the claim is included within the audit period of a medical record review.

Meeting Quality Management & Short-Doyle/Medi-Cal Requirements

Programs will be monitored for quality management and compliance with regulations by AMHS Quality Improvement Unit. Programs shall be required to submit and implement a QI Plan or Improvement or QI Plan of Correction for issues/problems identified by the QI Unit. The deadline for any quality improvement plan shall set by the QI Unit based on the individual provider's situation.

QI Plan of Improvement/ Correction

The QI Unit monitors organizational and County providers on a regular and annual basis to evaluate the provider's performance in various delegated activities. Medical record reviews are conducted to ensure that MHP contract requirements are met pertaining to documentation standards. Site certification and recertification reviews are also conducted to ensure that all MHP onsite requirements are being adhered to by the provider. If the provider's performance is found to be inadequate, or areas for improvement are identified, a request for QI Plan of Improvement/ Correction will be issued by the MHP to the provider.. The provider will have 30 days, or another identified time frame, after receipt of the MHP's written report of findings to complete and submit the specified QI Plan to the QI Unit. The QI Plan must describe the interventions or processes that the provider will implement to address items that have been

identified out of compliance or that were identified as needing improvement. In some instances, the QI Unit will be making more specific process improvement recommendations to the provider that must be included in the Plan of Improvement/Correction . When appropriate, the Plan must include all supporting documentation (i.e. copy of a policy and procedure that has been written, description of a system that program is implementing, copy of sign-in sheets from a training, etc.). Even when supporting documentation is not requested to be submitted with the Plan, the program is still required to keep this documentation on-file at their program. The Plan of Improvement/Correction must also include identified timelines and/or dates as to when the out of compliance item or area needing improvement will be implemented or completed. Pursuant to the "Withholding of Payment" clause of the contract, failure to respond adequately and in a timely manner to a request for a POC may result in withholding of payment on claims for non-compliance.

Upon receipt of a Plan of Improvement/Correction, the QI Unit will review what has been submitted to ensure that it adequately addresses the identified items. If the determination is made that the Plan does not adequately address these items, the QI Unit will request that an addendum to the Plan be submitted within a specified time frame.

Programs will be monitored for trends and patterns in any areas found out of compliance or areas needing improvement. Additional QI reviews may occur if a program has an inordinately large number of variances, certain trends and patterns are noted, or is largely out of compliance with standards or contract requirements. These determinations will be made under the direction of the QI Program Manager and may take place within 30 days, 60 days or some other identified time frame depending upon the severity of the noncompliance. For medical record reviews, these additional reviews will include the billing audit and will be subject to recoupment.

When a program's identified trends and patterns for out of compliance items or areas needing improvement are not responding to the program's written Plan of Improvement/Correction, QI may request that the Program COTR issue a Corrective Action Notice (CAN) to the program's Legal Entity. The CAN, give to the Legal Entity, , will include a description of the noncompliance categories, history of program's Plan of Improvement/Correction actions, and a statement about insufficient improvement having been made. QI may recommend identified interventions or process changes to be implemented. If a Corrective Action Notice is issued to a Legal Entity, additional County Departments become involved in monitoring remedial activities., Failure to respond adequately and in a timely manner to a required Corrective Action Notice may result in a withholding of payment on the claims for non compliance and could result in putting the contract at risk.

Medical Record Reviews

The MHP mandates site and medical record monitoring of providers to ensure that all clients receive the highest quality clinical care at the most appropriate levels of service. The Quality Improvement Unit conducts program site and medical record reviews. Site visits and medical record reviews are scheduled and coordinated with the Program Manager at each provider site.

A copy of the site and medical record review tool is distributed to the Program Manager prior to the scheduled review.

During the medical record review, a Quality Improvement Specialist will review clinical records for:

- Admission Checklist
- Assessment/Appropriateness of Treatment
- Medical Necessity
- Clinical Quality
- Client Treatment Plan and Client Involvement
- Compliance with Medi-Cal, State, Federal, and County Documentation Standards
- Billing Compliance
- Medication Treatment/Medical Care Coordination
- Administrative/Legal Compliance
- Care Coordination
- Discharge

Staff Signature Logs

All organizational providers are required to maintain an accurate and current staff signature log that includes all staff that document within the program's clinical records. The MHP requires that this staff signature log include the following elements for each staff person:

- Typed name
- Signature
- Degree and/or licensure
- Job title
- Language capability, if applicable

It is very important that the signature on the log be readily identifiable to the staff person's signature as it appears within the medical record. A staff log signature that is not readily identifiable to the staff's signature within the medical record could place the service provided at risk of disallowance.

To ensure that the log is kept current, it is the organizational provider's responsibility to update and maintain the log in a timely manner to reflect any changes, i.e. licensure, degree, job title, name, or signature. The staff signature log must be maintained onsite at the organizational provider's program location, and be made available at the request of the MHP for purposes of site visits, medical record reviews, etc. Failure to maintain a staff signature log that is accurate and current will result in a plan of corrective action being issued to the organizational provider.

Medical Record Claims Review

As part of the coordination process for a medical record review with the program, the QI Specialist will notify the program manager of the designated audit period for the billing claims review. The designated billing review period will include the month, date, year that the billing review begins and ends. All billings for the designated period will be reviewed on those medical records that are selected for review. At the conclusion of each medical record review, the QI Specialist will present preliminary findings of the review at an on-site exit conference.

Invalid Services- formerly Service Deletions

In order to maintain a complete audit trail, services entered in Anasazi cannot be deleted. For services that would have previously been deleted, e.g. through provider self reports of disallowances, Billing Unit staff will mark the service with an Invalid Service Denial Code.

For additional information, please consult the San Diego County Mental Health Services Financial Eligibility and Billing Procedures volume of the Organizational Providers Manual

For additional record reviews that are conducted by entities other than the MHP (i.e. Department of Mental Health as part of the Mental Health Plan's Compliance Review or for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical record reviews) the same practice of Marking Invalid Service Denial Codes will apply.

Medi-Cal Recoupment and Appeals Process

It shall be the policy (Recoupment Based on Medical Record Review; No: 01-01-125) of County of San Diego Mental Health Services to disallow billing by Organizational, County, Individual and Group providers that do not meet the documentation standards set forth in the Uniform Clinical Record Manual and to recoup Federal Financial Participation (FFP) in accordance with the current *California State Department of Mental Health Reasons for Recoupment of Federal Financial Participation Dollars, Non-Hospital Services* (*see Appendix G – A.G.1*).
Per the current California State DMH Reasons for Recoupment of FFP Dollars, AMHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity
- Client Plan
- Progress Notes.

Located in *Appendix A.G.1* is the complete listing of recoupment criteria based on the above categories. Organizational and County providers shall be responsible for ensuring that all medical records comply with Federal, State and County documentation standards when billing for reimbursement of services.

At the conclusion of each medical record review, the provider will receive a Medi-Cal Recoupment Summary listing all disallowed billings based on the DMH reasons for recoupment criteria. If the provider disagrees with a Medi-Cal recoupment, AMHS Quality Improvement has developed a 2-level process for a provider who wishes to appeal a Medi-Cal recoupment decision. Providers must submit their appeals in writing to the Quality Improvement Unit within required timelines. Located in *Appendix G (A.G.2)* is the complete description of the step-by-step appeal process with timelines for first and second level appeals.

Actions Regarding Reasons for Recoupment

The Mental Health Billing Unit will mark services that would have previously been deleted with an Invalid Service denial code at the time the results of the medical record review are considered final, i.e. after completion of the appeal process or provider's decision not to appeal.

For additional information, please consult the San Diego County Mental Health Services Financial Eligibility and Billing Procedures volume of the Organizational Providers Manual

Annual Site Reviews

The Quality Improvement Unit is also responsible for monitoring the health and safety of organizational provider sites. Providers must be in compliance with all Federal and State regulatory requirements and MHP contract requirements with DMH. Annual site reviews are conducted to ensure that providers comply with necessary licenses/certification requirements, maintain a safe facility, and store and dispense medications in compliance with all pertinent Federal and State standards. During the site review visit, a Quality Improvement Specialist may review:

- Physical Plant/facility
- Health and Safety Requirements
- Licenses and Permits
- Required Program Documents
- Personnel
- Medication Service
- Cultural Competence
- Consumer Orientation
- Staff Training & Education
- Client Rights, Grievance & Appeals Process, and Advance Directives
- Staff knowledge of current Organizational Provider Operations Handbook

Medication Monitoring

State and County AMHS regulations require all organizational providers with programs prescribing medication in the course of their services to have a medication monitoring system. Current State Department of Mental Health (DMH) requirements for Medication Monitoring (MM) are set forth in CCR, Title 9, Chapter 11, Section 1810.440; MHP Contract with DMH, Exhibit A, Attachment 1, Appendix A, B.4. The primary purpose of medication monitoring is to ensure the most effective treatment. Areas monitored include:

- Medication rationale and dosage consistent with community standards
- Appropriate labs prescribed
- Consideration of physical health conditions
- Effectiveness of medication(s) prescribed
- Adverse drug reactions and/or side effects
- Evidence of signed informed consent
- Client adherence with prescribed medication and usage
- Client medication education and degree of client knowledge regarding management of medications.

Within the MHP system, open records of medication services for all County-operated and contracted programs are sampled on a 5% per annual basis.

Contracted providers are required to perform the first-level screening of medication monitoring for their facility, using the Medication Monitoring Screening Tool. If a variance is found in medication practices, a Medication Monitoring Feedback Loop (McFloop) form is completed, given to the psychiatrist for action, and then returned to the Medication Monitoring Committee for approval. Results of medication monitoring activities are reported quarterly by the 15th of each month following the end of each quarter to the QI Unit on the Medication Monitoring Committee Minutes form. All completed McFloop forms shall be sent to the QI Unit within 30 days of the reporting deadline for each quarter. *(The Medication Monitoring Screening Tool (A.G.3), Committee Minutes form(A.G.4) and McFloop form(A.G.5) are located in Appendix G.)*

The Health and Human Services Agency Pharmacy is responsible for performing the medication monitoring for County-operated facilities. The Chief of Pharmacy submits a written quarterly report that includes results of screening and clinical review activities to the clinic program managers and the Mental Health Quality Improvement Unit.

The QI Unit evaluates the reports from both the contractors and Chief of Pharmacy for trends, compiling a summary report submitted to the Quality Review Council (QRC) and County

Pharmacy and Therapeutics Committee (P&T) quarterly. If a problematic trend is noted, the report is forwarded to the Medical Director for recommendations for remediation.

Medi-Cal Certification and Recertification

Contracted and County providers shall be familiar with the Short-Doyle/Medi-Cal delivery system and shall become Medi-Cal certified prior to commencing services and billing Medi-Cal. Providers who bill for Medi-Cal services will be recertified every three (3) years. The re-certification review will include review of the following:

- Compliance with all pertinent State and Federal standards and requirements
- Maintenance of current licenses, permits, notices and certifications as required
- Policies & Procedures or process
- Compliance with the standards established in the Mental Health Services Quality Improvement Plan
- Physical plant/facility requirements
- Adherence to requirements for ensuring the confidentiality and safety of client records
- Medication service
- Adherence to health and safety requirements
- Fire Clearance Requirements for Short-Doyle Medi-Cal Programs

  As part of the Short-Doyle Medi-Cal Certification process for new programs or Certification of Short-Doyle Medi-Cal programs that are relocating, the organizational provider will:

  - Secure a new fire clearance document from their local fire code authority and submit a copy to the San Diego County Mental Health Service's Quality Improvement Unit.
  - After receipt of the fire clearance document a site visit will be scheduled. Note: All fire clearance documents must be kept at the program site and be available to reviewers.

  Prior to a Short-Doyle Recertification visit (every 3 years) of a current operating site, the organizational provider must make available to the reviewer the most recent site fire clearance document and all previous fire clearance documents. Providers will be in compliance if the most recent fire clearance document has been completed within three (3) years of the previous fire clearance document date. If the most recent fire clearance document has not been completed within the three (3) year period or fire clearance document (s) are not found, the program will receive a Plan of Correction (POC) requesting the appropriate action (s) to be taken by the provider. The action (s) will be included in the POC and sent to San Diego County Mental Health Service's QI Unit to review.

For any questions on this process please contact Ian B. Rosengarten, QI Specialist at 619-563-2777 or e-mail at ian.rosengarten@sdcounty.ca.gov.

ACCESSIBILITY OF SERVICES

The provider is responsible for preparing and maintaining appropriate records on all clients receiving services in compliance with CCR, Title 9, Chapter 11 and 42 CFR guidelines. This includes on site and secure maintenance of a written Request for Services Log (located in *Appendix C*). At a minimum, the log must contain the name of the individual, the date of the request, the nature of the request, and the initial disposition of the request. For outpatient services, AMHS requires providers to keep records of the urgency status of each request. It is strongly suggested that providers also keep records of the consumer's insurance coverage, and whether the client telephoned or walked in to request services.

The provider is expected to meet the MHP standards for access to emergent, urgent and routine mental health services to ensure that clients receive care in a timely manner. These access standards refer to the acceptable timelines for triage, intake, assessment, and clinical evaluation. The MHP will be monitoring compliance according to established industry standards and a mandate by the San Diego County Board of Supervisors (see Section C for a review of these standards).

Guidelines for Orientation Groups

Orientation groups were implemented in some outpatient programs in San Diego County in order to, educate clients about services and to assist them in completion of required client paperwork prior to a clinical appointment.. While orientation groups may aid programs in meeting these objectives, it is critical that program staff understands that the use of Orientation Groups may not create a barrier to accessing services and may not be counted as a first appointment for Wait Times purposes.

New clients who are being discharged from a hospital or crisis residential facility shall not be required to attend an orientation group prior to receiving a mental health and/or psychiatric assessment. Clients who choose not to or are unable to attend an Orientation Group must be given alternative ways to receive the information shared in this meeting and cannot be denied a mental health assessment based on attendance or non-attendance..

It is the responsibility of each Program Manager to train appropriate staff on the limitations regarding the use of Orientation Groups, and the inability to count a group as a first appointment for Wait Times purposes.

Wait Times
Report Due: *Data to be reported on the Monthly Status Report*

Another measure of system efficiency is the amount of time clients have to wait to receive services. County-operated and designated contracted providers of outpatient assessments and medication evaluations shall report track Wait Times information each week to AMHS. Data shall include the previous month's information on client access (waiting time) for routine initial mental health and psychiatric assessments. For technical support and questions on the Wait Times Program, contact Scott Wade in the QI Unit at 619-563-2762 or by email at Scott.Wade@sdcounty.ca.gov.

The Wait Time (for both Mental Health and Psychiatric Assessments) is defined as the time between the initial contact from a new client requesting services until the first *available* assessment appointment, which may be for a face-to-face screening or complete Mental Health Assessment. Orientation Groups cannot be considered as an assessment, nor can Wait Times for mental health or psychiatric assessments be calculated using attendance at Orientation Groups as a starting point.

Wait Time benchmarks have been established for each outpatient program based on historical data. Wait Times are monitored by the Performance Outcomes Group of QI , and any program that consistently exceeds its Wait Time benchmark will be required to submit a quality improvement plan.

Wait Times for Emergency and Urgent Services:

- Any client who needs emergency service (inpatient hospitalization) shall have his/her needs addressed within one hour.
- Any client who meets the criteria for needing "urgent" services shall been seen within 72 hours. A need for urgent services is defined as a condition, which, without timely intervention, is certain to result in a person being suicidal, homicidal or gravely disabled, and in need of emergency inpatient services. Any person being discharged from a crisis residential facility, a psychiatric hospital, the EPU or a locked/IMD placement who is screened as needing services urgently shall be seen with 72 hours. Any new client who calls for services and is screened as needing services urgently also meets the "urgent" criteria and shall be seen with 72 hours. All urgent services must be tracked on the Request for Services Log.

CLIENT AND PERFORMANCE OUTCOMES

Monthly Status Report (MSR)
Report Due: *No later than the 15th calendar day of each month for the preceding month. County Mental Health Administration has agreed to accept the MSRs on the 20th of the month until further notice.*

Providers are required to submit a monthly status report which gives the MHP vital information about provider services. All sections of the report not specifically marked "Children" must be completed. The report has been revised to include sections for reporting client outcomes and possible participation in Medicare Part D. Additionally, the form includes a place to report monthly on staffing and cultural competence training. The MSR form is updated periodically in accordance with changing State, Federal and County regulations and individualized for each provider in keeping with their contract requirements. A copy of the basic MSR is included in *Appendix G (A.G.6).*

Client Outcomes
Report Due*: Included as part of the Monthly Status Report due the 15th calendar day of each month for the preceding month. County Mental Health Administration has agreed to accept the MSRs on the 20th of the month until further notice.*

In conjunction with new State and Federal mandates to show program effectiveness and client progress in rehabilitation and recovery, the MHP has extended the Client Outcomes tracking to almost all Outpatient and Case Management programs; If you think that client outcomes tracking may not be feasible due to the special nature of your program, please contact System of Care Monitor (COTR, RPC) to discuss a possible exemption..

New outcome measures were chosen in June, 2009 to better reflect the recovery orientation of the MHP. A provider advisory group, the Health Services Research Center (HSRC), and Mental Health Administration worked together for two years to select and pilot tools to make the most appropriate choice for the San Diego MHP. Beginning in July, 2009, HSRC is bringing the new measures to each provider. After an on-site provider staff training, each organization is implementing the new measures immediately. Until the Anasazi electronic assessment is operational at each provider's site (expected incrementally between January and August, 2010), providers are to fax completed client and clinician tools to HSRC.

In determining what indicators to select as part of the performance measurement system, San Diego County A/OAMH continued to use the following criteria: meaningfulness, applicability, availability, compatibility with California programs and priorities, and ease of use.

The client outcomes indicators currently being used are:

- Recovery Markers Questionnaire (RMQ)—a consumer-driven assessment of the client's own state of mind and body and life, and involvement in the recovery process.
- Illness Management and Recovery (IMR)—a tool completed by clinicians which ranks a client's biological vulnerability and socio environmental stressors. The IMR Program is an evidence-based practice designed to help clinicians assist clients develop personal strategies to manage their mental health issues and advance toward their goals. The IMR also includes questions about changes in a person's residential, employment, or education status.
- DMH Adult Survey—a client-completed, twice yearly State mandated survey tool which includes Mental Health Statistics Improvement Program (MHSIP) client satisfaction measures as well as the California Quality of Life measures which include indicators of improvement or stabilization of community functioning.
- Recovery Self Assessment (RSA)—one tool for clients and a second for clinicians which will be completed twice yearly in conjunction with the Adult Survey discussed above. The RSA measures perceptions of provider practices thought to be indicative of a recovery-oriented environment. The client survey is attached to the State Adult Survey. The clinician survey about agency recovery orientation is sent to providers in the State Adult Survey packet.
- Substance Abuse Treatment Scale-Revised (SATS-R) –measures improvement or stabilization in a consumer's stage of substance abuse treatment

Systemwide Outcomes

Every three years starting in September/October, 2009, Program Managers or Administration will be asked to complete a short Recovery Self Assessment tool designed to measure progress toward the recovery-orientation of each program as a whole. The data from this tool will be used to help agency personnel and stakeholders review their relative standing in comparison to other programs in the same level of care, their strengths, and areas of improvement.

Mental Health Services Act (MHSA) Outcomes

Under the MHSA in San Diego, many new programs have been started while others are expanding. As new phases of MHSA continue to be implemented and expanded across the State, new requirements for outcome reporting are anticipated to document how these funds are changing the lives of mental health clients. Providers receiving MHSA funding will be responsible for complying with any new requirements for additional outcome data. Currently, all types of programs that have entered into Full Service Partnerships under the MHSA are required to participate in a direct State data collection program which tracks initial specialized client assessments, ongoing key incident tracking, and quarterly assessments.

Performance Improvement Projects (PIPs)

The State has mandated that each county be engaged in one administrative and one clinical performance improvement project each year in order to improve processes and outcomes of care. A PIP is a comprehensive, long-term study which includes a commitment to improving quality through problem identification, evaluating interventions and making adjustments as necessary. It may provide support/evidence for implementing protocols for "Best Practices." Progress on each PIP is evaluated annually by the External Quality Review Organization (EQRO), an independent State contracted organization.

The MHP may ask for your involvement in the PIP by:

- Implementing current PIP interventions/activities/procedures at your programs
- Supporting survey administration and/or focus group coordination at your programs
- Developing your own program's PIP projects

Incident Reporting

An incident that may indicate potential risk/exposure for the County – operated or contracted provider (per Statement of Work), client or community must be reported to the County. There are two types of reportable incidents. Serious Incidents are reported to the MHS Quality Improvement Unit. Unusual Occurrences are reported to the program's COTR.

Serious Incident Reporting To Quality Improvement Unit

All providers are required to report serious incidents involving clients in active treatment or whose discharge from services has been 30 days or less. Required reports shall be sent to the MHS Quality Improvement Unit who will review, investigate as necessary, and monitor trends. The MHS Quality Improvement Team will communicate with program COTRs and MHS management staff as needed on all reported serious incidents. The provider shall also be responsible for reporting serious incidents to the appropriate authorities.

Serious incidents are categorized as follows:

- ▲ Death, excluding natural cause, includes death by suicide
- ▲ Homicide by a client - attempted homicide by a client
- ▲ Suicide attempt resulting in severe physical damage and/or loss of consciousness, respiratory and/or circulatory difficulties requiring medical attention
- * For mental health clients: use of physical restraints (prone or supine)

- ▲ Adverse medication reaction resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- ▲ Medication error in prescription or distribution resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- ▲ Serious physical injury resulting in a client experiencing severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization
- ▲ Injurious assault on a client or by a client occurring on the program's premises resulting in severe physical damage and/or loss of consciousness; respiratory and/or circulatory difficulties requiring hospitalization

- Inappropriate staff behavior such as sexual relations with a client, financial exploitation of a client, and/or physical or verbal abuse of a client
- Major confidentiality breach (lost or stolen laptop, large number of client files/records accessed, etc.)

*Excluding Hospitals, Long-Term Care Facilities, San Diego County Psychiatric Hospital/EPU, and PERT

Please Note:

For the Serious Incidents identified with a ▲ above, The Serious Incident Report of Findings must include a confirmation that an in-depth analysis of factors contributing to the event has been completed. An example of the type of analysis expected is a "Root Cause Analysis" (RCA) (see http://www.jointcommission.org/sentinelevents/forms/ for more info on RCA). This type of analysis addresses systemic issues associated with serious incidents such as policy, processes and practice, rather then placing blame on individuals. Based on the results of the analysis the report of findings should describe what plans the program has for correcting those systemic factors that contributed to the event. Please note: In July, 2010 QI will have a standard in place requiring a Root Cause Analysis be completed for all Sentinel Events (▲those resulting in injury or death) and is developing a protocol that will be included in this manual as a guideline for analysis.

Serious incidents shall be classified into two levels with Level One being most severe and Level Two less severe. A Level One incident must include at least one of the following:

- The event is associated with a significant adverse deviation from the usual process for providing mental health care.
- The event has results in a death or serious physical injury on the program's premises.
- The event has the potential for significant adverse media involvement.

For a Level One incident, the provider shall telephonically notify the County Quality Improvement Unit at 619-563-2781 as soon as possible but no later than within 24 hours. The provider shall also complete a Serious Incident Report (see *Appendix G*) and fax it to the QI Unit within 72 hours.

For a Level Two incident, the provider shall telephonically notify the County QI Unit at 619-563-2781 within 24 hours and fax a Serious Incident Report *(Appendix A.G.7)* to the QI Unit within 72 hours.

Within 30 days of submitting a Serious Incident Report, the provider shall submit a Serious Incident Report of Findings (*Appendix A.G.8*) by mail or fax, summarizing the findings, identifying interventions, outcomes, and/or other improvements implemented as a result of the incident.

After review of the incident, the MHP may order a corrective action plan. The MHP is responsible for working with the provider to specify and monitor the recommended corrective action plan.

The MHS QI Unit will monitor trends of Serious Incident Reports and report to the QRC and Mental Health Administration Executive Team periodically and as required resolving any problematic issues.

Unusual Occurrence Reporting To COTR

An unusual occurrence is defined as an incident that may indicate potential risk/exposure for the County program, client, or community. Unusual occurrences may include but are not limited to:

- Alleged child abuse
- Police involvement.
- Inappropriate sexual behavior
- Self injury
- Physical abuse
- AWOL
- Fire setting
- Poisoning
- Major accident
- Property destruction
- Epidemic outbreak
- Physical injury

Notification to Agencies for Safety and Security Purposes

When Unusual Occurrences occur or are identified, the appropriate agencies will be notified within their specified timeline and format:

1. Children's Services Bureau Hot Line for child abuse reporting and injuries.
2. Intended victim and law enforcement, for Tarasoff reporting.
3. Law enforcement (police, sheriff, school police, agency security, military security/Naval Investigative Service, etc.) for crime reporting or requiring security assistance and inquiries.
4. Every fire or explosion which occurs in or on the premises shall be reported within 24 hours to the local fire authority or in areas not having an organized fire service, to the State Fire Marshall.

Notification by County and Contract Programs

County-operated or contracted Mental Health program providers are required to provide notification to their COTR within 24 hours when any Unusual Occurrences occur.

QUALITY REVIEW COUNCIL (QRC)

The Quality Review Council (QRC), mandated by State regulation, is a collaborative group with representation comes from many types of MHP stakeholders including clients and family members, County and contracted providers, associations and advocacy groups representing the mental health community, and hospital providers. The QRC meets regularly to review, discuss and make recommendations regarding quality improvement issues and trends that affect the delivery of services through the MHP. If you are interested in possible membership, please call the QI Unit at 619-563-2778.

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H. CULTURAL COMPETENCE

Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers, family member providers, and professionals that enables that system, agency or those professionals, consumer, and family member providers to work effectively in cross-cultural situations.

History and Background

Cultural norms, values, beliefs, customs and behaviors may influence the manifestation of mental health problems, the use of appropriate levels of care/services, the course of treatment and the successful attainment of positive outcomes. The County's demographic dynamics combined with the recognition that culture is a key factor in service delivery pose an ongoing challenge for the MHP and its contracted mental health care providers. The 2000 United States Census reports that racially and ethnically diverse groups comprised 25% of the total population, with continued growth expected. The demographics for San Diego County reveal magnification of that trend. According to the San Diego Association of Governments (SANDAG) growth forecast, ethnically diverse populations will increase from 40% of the population of San Diego County in 2000 to 51% in the year 2020.

As the diversity of the population continues to increase, the 2003 –2004 Cultural Competence Plan San Diego County Mental Health noted an increase in the number of Medi-Cal mental health clients from various minority populations, but found minority populations under-represented among total mental health clients. For example, as of 2002, 26% of the County population was Hispanic, but only 12% of the mental health clients are from this ethnic group and only approximately 13% of direct service providers. A disparity was also found between the number of minority clients participating in the Medi-Cal program and the number of clinicians available with self-assessed proficiency in needed cultural specialties.

The Cultural Competence Plan reports that in addition to changing demographics related to ethnicity and race, age demographics are changing in the county and will affect service demands. The child population is the most rapidly increasing portion of the population. The number of older adults living in San Diego is also growing, with 18% of the target population being 56 plus years of age.

Cultural Competence Plan

To address these issues in the 2003-2004 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

1) Conduct an ongoing evaluation of the level of cultural competence of the mental health system, to be based on an analysis of gaps in services that are identified by comparing the target population to provider staffing

2) Investigate possible methods to mitigate identified service gaps
3) Enhance cultural competence training system-wide
4) Evaluate the need for linguistically competent services through monitoring usage of interpreter services
5) Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs
6) Study and address access to care issues for underserved populations.

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

Clinical Practice Standards:

The Culturally Competent Clinical Practice Standards currently utilized by SDCMHS were originally written in 1998. These standards have been revised by the Cultural Competence Resource Team (CCRT) in order to ensure that the Clinical Practice Standards would: 1) promote and encourage values and approaches that are necessary for the support and development of culturally competent practices; 2) increase and improve knowledge and understanding of concepts and information critical for the development and implementation of culturally competent practice, and; 3) establish goals for the development/improvement of practice skills of all members in the system to ensure that cultural competence is an integral part of service delivery at all levels.

The revised standards are as follows:

1) Providers engage in a culturally competent community needs assessment.
2) Providers engage in community outreach to diverse communities based on the needs assessment.
3) Providers create an environment that is welcoming to diverse communities.
4) Staffing at all levels, clinical, clerical, and administrative, shall be representative of the community served.
5) There is linguistic capacity & proficiency to communicate effectively with the population served.
6) Use of interpreter services is appropriate and staff is able to demonstrate ability to work with interpreters as needed.
7) Staff shall demonstrate knowledge of diversity within ethnic and cultural groups in terms of social class, assimilation, and acculturation.

8) Staff shall demonstrate knowledge about a) specific cultural features that may be present in various disorders, b) culture-bound syndromes, c) cultural explanations of illness, d) help seeking behaviors, include faith-based, in diverse populations, and e) appreciation for traditional ethnic and cultural healing practices.
9) Cultural factors are integrated into the clinical interview and assessment.
10) Staff take into consideration the potential bias present in clinical assessment instruments and critically interpret findings within the appropriate cultural, linguistic and life experiences context of the client.
11) Culture-specific consideration consistent with the cultural values and life experiences of the client shall be integral in the intervention and shall be reflected in progress notes, treatment planning and discharge planning.
12) Psychiatrists consider the role of cultural factors (ethnopsychopharmarcology) in providing medication services.
13) Providers promote an environment that encourages staff to conduct self-assessment as a learning tool.
14) Staffs actively seek out educational, consultative and multicultural experiences, including a minimum of 4 hours of cultural competence training annually.

Staffing Requirements:
To support the cultural competence standards, providers are required to take the following steps:

1. Develop policies and procedures that support culturally competent services and provide training to staff.
2. Contractors are encouraged to provide a Human Resource Plan (e.g. Cultural Competence Plan) that includes how contractor will recruit, hire and retain bilingual and culturally diverse staff.
3. Staff should reflect the specific cultural patterns of the region to the maximum extend possible.
4. Providers are to recruit staff who can meet the language needs of their clients.
5. Include in job applications questions regarding experience in working with ethnic/minority clients, and/or culture communities for direct service or interpreting positions.
6. Establish a method or process for ensuring that staff who indicate they are bi/multi-lingual have the language capability to appropriately communicate ideas, concerns, and rationales.
7. Contractor shall ensure that program staff is knowledgeable of the culturally diverse backgrounds of the clients.
8. Establish a method or process for ensuring that staff who indicate they are bi/multi-cultural have knowledge of culturally appropriate evaluation, diagnosis, treatment, referral resources, and familiarity with culturally variant beliefs regarding mental illness.
9. Require that at a minimum, all provider staff, including support staff dealing with clients or anyone who provides interpreter services, must participate in at least four (4) hours of cultural competence training per year. Training may include attending lectures, written

coursework, review of published articles, web training, viewed videos, or attended a conference can count the amount of time devoted to cultural competence enhancement. A record of annual minimum four hours of training shall be maintained at the program site.

10. Train direct services staff on MHP Cultural Competence Clinical Practice Standards and establish a process for monitoring adherence to the standards.

Cultural/Ethnicity Requirements:

Consumers must be given an initial choice of the person who will provide specialty mental health services, including the right to use culturally specific providers. Providers are also reminded that whenever feasible and at the request of the beneficiary, clients have the right to request a change of providers.

Language Requirements:

Services should be provided in the client's preferred language. Providers are required to inform individuals with limited English proficiency in a language they understand that they have a right to free language assistance services. There shall not be the expectation that family members provide interpreter services, including the use of minor children. A consumer may still choose to use a family member or friend as an interpreter, only after first being informed of the availability of free interpreter services. The offer of interpreter services and the client's response must be documented.

Progress notes shall indicate when services are provided in a language other than English. Providers are also reminded that, whenever feasible and at the request of the beneficiary, consumers must be given an initial choice of or the ability to change the person who will provide specialty mental health services, including the right to use linguistically specific providers.

Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. The Access and Crisis Line, the EPU, and the Center for Community Health Education and Advocacy are Mandated Key Points of Entry for all threshold languages. In addition the following clinics are also designated as Mandated Key Points of Entry for the languages listed:

- Spanish
  - EPU
  - All Outpatient and Case Management programs
- Vietnamese
  - UPAC
- Tagalog
  - UPAC
- Arabic
  - East County Mental Health

All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients language needs whether the language is a threshold language or not.

Facility Requirements:

In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations. Program hours of operation must be convenient to accommodate the special needs of the service's diverse populations.

Additional Program Standards

Programs will also be encouraged to do the following:

1) Develop and implement a Cultural Competence Plan for each provider site/program.

- If providers have already developed a plan, they may continue to use their current plan to meet this requirement.
- Progress on plans made throughout the year may be noted in the MSR under QI activities.
- County can provide technical assistance for Cultural Competence Plan development.

2) If there is no process currently in place, develop a process to evaluate the linguistic competency of staff that is providing service or interpretation during services, in a language other than English. This may be accomplished through a test, supervision or some other reliable method. The process must be documented.

3) Conduct a survey or client focus group every couple of years and include clients who are bi-lingual and monolingual to assess program and staff cultural competence, assess community needs and what efforts the program is making to meet those needs. Topics that must be covered in the survey or focus group are:

- Regarding Language:
    - Offers of providers who speak the client's language, or interpreter services
    - Linguistic proficiency of staff providing services or of interpreter if one is used
    - Staff's ability to clearly communicate ideas, concerns, and rationales in client's preferred language
    - Availability of written materials, including alternate formats in client's preferred language

- Regarding Cultural/Ethnicity:
  - Direct services staff's knowledge of culturally appropriate evaluation, diagnosis, and treatment
  - Direct services staff's knowledge of culturally appropriate referral resources
  - Direct services staff's familiarity with variant beliefs regarding mental illness
  - Appropriateness of clinic environment
- Results shall include outcomes, findings, and plans for interventions as needed.
- The County can provide technical assistance with developing survey/focus group questions.

4) Conduct a survey or focus group at least once and periodically if needed in the community to assess broader cultural competence issues that may be creating barriers to services.

- The County can provide technical assistance with developing survey/focus group questions.

Monitoring Cultural Competence

The MHP QI Unit is responsible for monitoring compliance with cultural competence standards as outlined in the County's Cultural Competence Plan and with State and Federal requirements. The QI Unit utilizes both the medical record review and site review process to monitor providers regarding cultural competence. To assist in the assessment of the cultural competence of staff system-wide, providers are asked to report the cultural and linguistic background of all staff members on the Monthly Status Report, including experience and training with any diverse population so that QI may compare the availability of staff to target population.

Evaluating Cultural Competence

Program competence- SDCBHS and the Cultural Competence Resource Team have developed a self-assessment survey tool that can be used to assess the current level of cultural competence of programs. This survey tool, the Culturally Competent Program Annual Self-Evaluation (CC-PAS), was piloted at three program sites to assess it's usefulness. This tool can be found in *Appendix A-H-1*. The CC-PAS is not currently required unless noted in your contract, however, providers are encouraged to use this tool to establish a baseline of cultural competence in FY 09-10. There is a possibility that this tool will become a requirement at some point in the future.

Staff competence - SDCBHS and the Cultural Competence Resource Team have identified the following methods for evaluating staff competence: 1) use of the California Brief Multicultural Competence Scale (CBMCS) or other standardized measure, 2) conducting a survey amongst their clients to determine if the program's clinical and administrative services are perceived as culturally competent, 3) conducting a survey amongst their clients to determine if the program's

clinical and administrative services are perceived as linguistically competent. The CBMCS is available on line. Surveys can be developed independently or if providers prefer samples of surveys will be published in a new Cultural Competence handbook that is being drafted, and will be available soon.

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I. MANAGEMENT INFORMATION SYSTEM

Anasazi

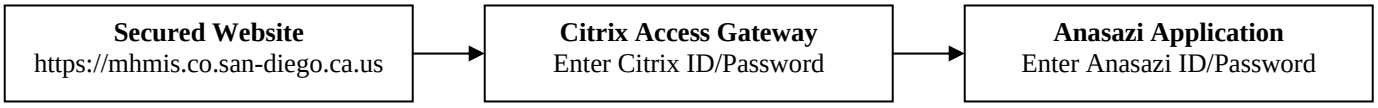
San Diego County Mental Health Services contracted in 2006 with Anasazi Software to create a new Mental Health Management Information System (MH MIS). Previously there was one system for client tracking/billing and one for managed care authorizations. The new MH MIS replaces the two systems with one integrated system. All client information, including clinical documentation, will be entered into this integrated system, thus allowing each staff responsible for a client's care to access that client's pertinent information.

For the complete **Management Information System: Anasazi User Manual**, go to the UBH Public Sector Website at https://www.ubhonline.com/publicSector/ (Note that the "S" in "publicSector" is capitalized. If you do not enter the capital "S", you will not access the website.)

User Account Setup and Access

The Mental Health Management Information System (MH MIS) is used by County and contract operated programs for client tracking, managed care functions, reporting and billing. An electronic health record (EHR) will replace much of what is contained in the paper medical record. Many controls are built into the software and hardware to safeguard the security and privacy of client personal health information.

MH MIS uses Anasazi Software which is a web based application that is housed on the County of San Diego Network. Network access to County data systems, including MHMIS, is the responsibility the County Technology Office (CTO). Security and maintenance of the County network is outsourced to the County's Information Technology Outsourcing Contractor (ITOC). Under the direction and oversight of the CTO, the ITOC is responsible for the security of the county network, the Citrix Access Gateway and maintenance of the County's servers which host the Anasazi application. In addition, the ITOC is responsible for the set up and maintenance of Citrix user network accounts. The following diagram demonstrates the access to Anasazi through the County network secured internet website using the Citrix Access Gateway.



System Administration responsibility for MH MIS is shared between the Administrative Services Organization (ASO) and the County's Mental Health MIS Unit.

- The Mental Health MIS (MH MIS) Unit is responsible for managing access, security, and menu management in Anasazi in accordance with County, State and Federal HIPAA

regulations. The MH MIS Unit is also the gatekeeper who ensures that staff is only given access pursuant to contract agreements. In addition, the MH MIS Unit is responsible for coordination among the CTO, ITOC and the ASO.

The ASO is responsible for other system administration activities such as table management, system maintenance, updates to the application, managing the five Anasazi environments, producing reports for legal entities, electronic submission of state reporting, coordination with Anasazi Software, and providing the User Support Help Desk.

Technical Requirements to Access Anasazi

Prior to accessing the Anasazi application via the internet, there are some basic technical requirements. For questions about whether an individual user or program site meets the basic technical requirements, it is recommended that the individual or program contact their company's IT department. The ASO may also be able to provide some technical assistance.

In order to access and operate Anasazi the following are required:

- Operating System on computer:
  - Windows 2000 (Citrix 10.0 does not supports Windows 95/98)
  - Windows XP Pro
  - Windows XP Home
  - Windows 2003 Server (if used as a client)
- Internet Explorer version 5.0 or later with a minimum of 24 kbps per concurrent user (high speed internet access)
- A Citrix compatible printer (most newer printers today are Citrix compatible)
- Download Citrix Presentation Server Client file on the user's computer

Staff Set Up and User Account Access

All individuals who provide services or perform some other activity to be recorded in MH MIS as well as those who are authorized to access MH MIS must have a staff account. A "staff" in Anasazi is defined as an individual who is employed, contracted or otherwise authorized by his or her designated legal entity or County business group to operate within the County of San Diego public mental health System of Care and whose primary job function may include any one of the following: to provide Mental Health Services, Quality Assurance activities, enter data, view data, or run reports. This includes clinicians, doctors, nurses, office support staff, financial/billing staff, research/analyst staff and program managers/administrative staff. All staff will be assigned a staff ID, which is a numerical ID ranging from 15 numbers. (**Note:** If a person is employed by more than one legal entity, he/she will have a unique staff ID for each legal entity.)

MANAGEMENT INFORMATION SYSTEM

Staff is given access to specific Unit(s)/SubUnit(s) based upon the program(s) where they work. Staff is also given access to specific menus based on their respective job functions. A list and definition of menus is available on the Anasazi Request Form. For additional information regarding staff or program access contact the SDCMHS MIS System Administration.

Staff authorized to access MH MIS will be given login access and a password and are considered "users".

User Access requires the following steps:

1. Program manager completes the "Anasazi Request Form" (ARF) (*Appendix A.I.1*).

2. Contractor employee must also read and sign the County's "Summary of Policies" (SOP) form (*Appendix A.I.2*). This must also be signed by the employee's supervisor.

3. Fax all completed forms to the **MH MIS Unit Fax at (858) 467-0411.**

4. MHMIS Unit completes the County's "Computer Services Registration Form" (CSRF).

All forms **must** be typed, and contain all necessary information. Incomplete forms will be returned to the contact person listed on the form. Once completed correctly, the forms must be re-faxed to MH MIS Unit. Please ensure forms are completed correctly to avoid delay in user account setup.

Once all forms have been submitted, the MH MIS Unit will:

1. Complete and process the CSRF for set up of a Citrix User Account with ID/password

2. Set up Anasazi User Account with ID/password

3. User will be provided his/her Citrix/Anasazi ID/passwords at the Anasazi training.

Program managers and other supervisors are responsible to:

1. Register new staff who will be users to attend the "New User Anasazi Training"

2. Contact the QI Unit to confirm Anasazi training date/time/location

3. Confirm that employee has successfully completed Anasazi training

Note: No user will be granted access to Anasazi without successfully completing the Anasazi Training.

All forms with instructions are available electronically on the ASO's (UBH) Public Sector website at https://www.ubhonline.com/publicSector/

Staff Assignment to Unit(s) and SubUnit(s)

On the ARF, the program manager will be assigning each staff to specific Unit(s) and SubUnit(s) based upon the program(s) where the staff performs work. Staff may be assigned to a single or multiple Unit/Subunits. The Unit/SubUnit number(s) must be reflected on the Anasazi Request Form. The MH MIS Unit will monitor staff access to Units/Subunits to ensure that staff has been assigned correctly. Under no circumstances, should a staff person be assigned to a Unit/Subunit if that staff person does not perform work for that program. This would constitute a violation of security and client confidentiality.

User Assignment to a Menu Group

Each user is granted restricted access to MH MIS based on his/her job requirements. One of the ways that access is restricted is through assignment to Units and Subunits described above. In addition, access is further restricted by assignment to a menu group. A menu group defines the screens and reports the user will be able to access and whether the user can add/edit or delete for each of those screens. For example, the user may only be able to view but not change data in one screen but may have rights to add data or edit previously entered data for another screen. Menu groups are created based on multiple criteria such as security, level of access to client information, staff job functions, staff credentials and state and federal privacy regulations.

On the ARF, the program manager or supervisor is responsible for requesting the menu group assignment for each user based on his/her job functions. A user may only be in one menu group at a time. Therefore, it is important for the program manager/supervisor to determine which menu group is the best match for the job functions performed by his/her staff.

For example, there will be menu groups for:

- Data entry staff with full client look up rights
- Data entry staff with limited client look up
- Clinicians
- Program managers and supervisors
- Quality Assurance
- Billing staff
- Research and Analysts

Refer to the ARF Instructions for a list and definition of available menus. The MH MIS Unit will review menu group requested by the program manager/supervisor and approve or modify the request.

Limitation of Staff Assignment to "Data Entry – Add New Clients" Menu Group

Program staff will be allowed to view information about a client currently or previously served by their program. Designated program staff will be given access to the "full client look up" in order to add new clients and assign existing clients to their subunit (program). These individuals will be allowed to view all clients in the system, including those not served by their program. Due to security and privacy issues, each program will be limited to two staff that will have this higher level of access. This access allows for data entry, adding new clients, full client lookup; entering demographic, diagnosis, insurance, and financial information (UMDAP); opening assignments; and running reports. Requests for exceptions to the two staff rule must be made in writing directly to and approved by the MH MIS Unit.

Staff Access to Live Production and Training Environment in Anasazi

For most users, after logging on to Anasazi through the Citrix Access Gateway, two visible Anasazi icons will be available for selection. One icon provides access to the Live Production environment used for data entry and reporting. The other icon provides access to the Training environment which is a copy of the set up of the live environment populated with fictitious client data. The training environment is used to train all new and returning users. Access to the training environment will remain available for ongoing training purposes. For example, on occasion, when there are upgrades to the Anasazi application, it may be necessary for staff to first practice in the Training environment prior to utilizing new functionality in the Live Production environment. Program managers and staff will be notified of changes to application functionality and will be instructed as to when the training environment should be utilized.

Program Manager/Supervisor Responsibility for Staff Access and Security

NOTE !
For system security, providers must notify UBH when staff with access to Anasazi move, change jobs, or are terminated.

The program manager/supervisor shall ensure that staff is in compliance with all County, State and Federal privacy and confidentiality regulations regarding protected health information (PHI). In addition, the program manager shall ensure that his/her staff is aware of the County's Security Policy regarding the protection of network/application passwords and use of County systems and data as outlined in San Diego County's "Summary of Policy". The program manager shall immediately notify the MH MIS Unit whenever there is a change in staff information such as staff demographics, email, job title, credential/licensure, and Unit/Subunit assignment. This includes the initial staff setup, modifying or terminating existing staff accounts**. Under no circumstances shall a staff person who has terminated employment have access to the EHR through Anasazi. This would constitute a serious violation of security which may lead to disciplinary actions.**

Staff Termination Process

- **Routine User Termination –** In most cases, staff employment is terminated in a routine

manner in which the employee gives an advanced notice. Within one business day of employee termination notice, the program manager shall fax to the MH MIS Unit (858) 467-0411 a completed ARF with the termination date *(will be a future date).* The MH MIS Unit will enter the staff expiration date in Anasazi which will inactivate the staff account at the time of termination and process the CSRF to delete the County network Citrix account.

- **Quick User Termination –** In some situations, a staff person's employment may be terminated immediately. In this case, the program manager must immediately call the MH MIS Unit at (619) 584-5090 to request the staff account be inactivated immediately. Within one business day, the program manager shall fax a completed ARF to the MH MIS Unit (858) 467-0411.

The MH MIS Unit is responsible for inactivating both the Anasazi and Citrix staff accounts.

Application Training

Prior to staff obtaining access to Anasazi, he/she shall successfully complete the Anasazi training. Program managers are responsible for registering new and returning Anasazi users for training on the Anasazi application. The Quality Improvement (QI) Unit provides training on a regularly scheduled basis. Previous Anasazi users returning to employment after more than 90 days of absence will be required to attend refresher training.

User Manuals

Users should be familiar with the MH MIS User Manual and the Financial Eligibility and Billing Procedures Manual, which contain detailed information about program workflow requirements using the MH MIS. These manuals are available on line at.
https://www.ubhonline.com/publicSector/

Security and Confidentiality

The County of San Diego is responsible for the protection of County technology and data and to monitor through its own policies and procedures user compliance with state and federal privacy and confidentiality regulations.

The County's Security mandates state that access will be given to a user at the least minimum level required by the user to execute the duties or job functions and that only those individuals with a "need to know" will be given access. Protection of County data and systems is also achieved via the use of unique user identification and passwords as well as other tracking methods.

Passwords

The sharing of passwords or allowing unauthorized individuals access into the system is strictly prohibited. A user's password is his/her electronic signature that is not to be shared or made available to anyone. Programs must ensure that the County's Policy and Procedures regarding security and confidentiality as stated in the Summary of Policies is complied with at all times. Failure to comply with these polices and procedures can result in the temporary or permanent denial of access privileges and/or disciplinary action.
MH MIS passwords:

- Must be changed every 90 days
- Must have a minimum of 7 characters
- Must contain a mix of letters & numbers
- May NOT be reused
- Are case sensitive
- Will be rejected if common words or acronyms are used

Unauthorized Viewing of County Data

All terminals and computer screens must be protected from the view of unauthorized persons. All confidential client information, electronic or printed, shall be protected at all times.

User Support

Users can obtain support through the ASO User Support Desk. The ASO User Support Desk can assist a user with the MH MIS application (technical assistance), MH MIS password issues, connectivity/access problems, printer problems, data entry questions, special requests, such as reports and Citrix access issues for contractors. For Citrix access issues (i.e. password reset), County employees must contact the County IT vendor.

In some cases, the ASO User Support Desk may refer the caller for second level user support, i.e. to the Mental Health Quality Improvement Unit for clinical issues and to the Mental Health Billing Unit for financial eligibility and billing issues.

The ASO User Support Desk may be contacted as follows:

Phone: 1-800-834-3792
Fax: (619) 6416975
Emails: helpdesk@sdubh.com

- User Support Desk hours: Monday through Friday, from 6:00 am to 6:00 pm except on holidays**.**

- Emergency Support is available 24/7 by pager (619) 8934839

For an operating system failure, contact your company's IT department. The IT department will determine the need for ASO User Support Desk involvement.

NOTE: Printing issues, password resets, technical and Anasazi application questions are not considered an emergency and will be handled the next business day.

QUICK RESOURCE GUIDE

1. MH MIS Unit Phone: 6195845090
2. MH MIS Unit Email: MH_MIS_SystemAdmin.hhsa@sdcounty.ca.gov
3. MH MIS FAX (ARFs and SOPs): 8584670411
4. ASO User Support Desk Phone: 18008343792
5. ASO User Support Desk 24 Hour Pager: 6198934839
6. ASO User Support Desk email: helpdesk@sdubh.com
7. Web address to access Anasazi: https://mhmis.co.sandiego.ca.us
8. ASO (UBH) Public Sector Website: https://www.ubhonline.com/publicSector/
9. County MH MIS Website: www.misupdate.org

J. PROVIDER CONTRACTING

Note: References to contracting do not apply to County-operated programs.

All Medi-Cal providers shall adhere to the Managed Care Contract executed between San Diego County and the California State Department of Mental Health. As outlined in that contract, Medi-Cal contractors are prohibited from subcontracting with a "legal entity" as defined in the California State Medicaid Plan for Short-Doyle/Medi-Cal services. The California State Medicaid plan defines legal entity as each county mental health department or agency and each of the corporations, partnerships, agencies, or individual practitioners providing public mental health services under contract with the county mental health department or agency. The prohibition on subcontracting does not apply to providers and their relationships with vendors such as nursing registries, equipment, part-time labor, physicians, etc. Such providers do not meet the legal entity definition cited above. The legal entity concept prohibits a county from contracting with a legal entity to provide Short-Doyle/ Medi-Cal services that in turn contracts with another legal entity to provide Short-Doyle/Medi-Cal services.

All non-County-operated organizational providers must contract with the County of San Diego in order to receive reimbursement for Specialty Mental Health Services. Please read your contract carefully. It contains:

- General terms applicable to all contracts;
- Special terms specific to a particular contract;
- A description of work or services to be performed;
- Budget schedules; and
- Statutes and/or regulations particular to the Medi-Cal managed mental health care programs as well as programs supported by other funds.

All contracted providers will be expected to adhere to these requirements. Please contact the Mental Health Services Contract Administration Unit (CAU) at 619-563-2733 if you have any questions regarding your contract.

NOTE!

Please read your contract carefully and keep it in a place where you can refer to it easily.

If you have any questions regarding your contract, please contact the Mental Health Services Contract Administration Unit at 619-563-2733.

Program Monitoring

Each provider will have assigned to their program a Program Monitor (also known as Contracting Officer Technical Representative – COTR), who will monitor compliance with outcome measures, productivity requirements and other performance indicators, analyze reports from providers, and provide programmatic review for budgets and budget variances in accordance with contract terms and conditions. Program monitors/COTR's hold regular providers meeting to keep providers informed on the System of Care. All provider contract questions should be directed to the assigned Program Monitor/COTR.

PROVIDER CONTRACTING

Contractor Orientation

All new contracts require a contractor orientation meeting within 45 days of contract execution. Agency Contract Support shall, in conjunction with the Mental Health Contract Team, be responsible for contractor orientation. Contractor will designate a contact person to coordinate attendance of necessary contractor staff at the orientation.

Notification in Writing of Status Changes

Providers are required to notify the Mental Health Services (MHS) Contract Administration Unit (CAU) COTR and QI in writing if any of the following changes occur:

- Change in office address, phone number or fax;
- Addition or deletion of a program site;
- Change of tax ID number or check payable name (only to CAU);
- Additions or deletions from your roster of Medi-Cal billing personnel (only to CAU); or
- Proposed change in Program Manager or Head of Service.

Site Visits

The County MHP will conduct, at a minimum, an annual site visit to all organizational providers. The County MHP includes MHS Program Monitor/COTR/Designee, MHS CAU, MHS Quality Improvement (QI) Unit, and the Health and Human Services Agency (HHSA) Contract Support. The site visit may include, but is not limited to, a review of:

- Compliance with contractual statement of work;
- Client medical records (where applicable);
- Building and safety issues;
- Staff turnover rates;
- Insurance, licensure and certification documentation;
- Fiscal and accounting policies and procedures;
- Compliance with standard terms and conditions.

Information from the site visit will be included in the contract monitoring process. For Medi-Cal providers, the site review is due at least annually. When a re-certification is due, the annual site review will be completed with the re-certification. Please see the *Quality Improvement Program* section of this handbook for a more detailed discussion of Medi-Cal provider site visits.

An additional note: Contractor's Program Manager shall be available during regular business hours and respond to the Program Monitor/COTR or Designee within 2 work days. Contractor shall have the technological capability to communicate, interface and comply with all County requirements electronically using compatible systems, hardware and software.

Corrective Action Notice
Corrective Action Notice (CAN) is a tool identifying deficiencies in compliance with contractual obligations and requires corrective actions within a specified time frame. A CAN may result from site visits or information derived from reports. Contractors are required to respond to the CAN specifying course of actions initiated/implemented to comply within the specified time frame.

Monthly Status Reports
Contracted providers are required to submit a completed Monthly Status Report (MSR) within 15 calendar days after the end of the report month. County Mental Health Administration has agreed to accept the MSRs on the 20th of each month until further notice. The MSR includes the NOA Log and Suggestion / Provider Transfer Request Log. Twice yearly, in July and December, the County submits a Cultural Competency Report to the State by extracting information provided on the MSR from the Staffing and Personnel as well as Training section of the MSR.

Contract Issue Resolution
Issues, problems or questions about your contract should be addressed to your Contracting Officer's Technical Representative (COTR) at their respective addresses.

Disaster Response
- In the event that a local, state, or federal emergency is proclaimed within San Diego County, contractors shall cooperate with the County in the implementation of a Behavioral Health Services response plan. Response may include staff being deployed to provide services in the community, out of county under mutual aid Contracts, in shelters, and/or other designated areas.
- Contractor shall provide BHS with a roster of key administrative personnel's after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. These numbers will be held confidential and never given out to other than authorized personnel.
- Contractor shall identify 25% of direct service staff to prepare for and deploy (if needed and available) to a critical incident. These staff shall participate in County provided Disaster Training (or other approved training) and provide personal contact information to be included in the Disaster Personnel Roster maintained by the County. Contractor shall advise COTR of subsequent year training needs to maintain 25% trained direct service staff in the event of staff turnover. Contractor shall maintain 25% staff deployment capability at all times.
- In the event that contractor's program site is closed due to disaster or emergency, contractor shall call the Access and Crisis Line and their COTR to inform them of this.

Transportation of Clients
Contractors shall not use taxi cabs to transport unescorted minors who receive services funded by the County of San Diego.

CLAIMS AND BILLING FOR CONTRACT PROVIDERS

Contractor Payments
Contractors will be paid in arrears. After the month for which service has been given, the MHS CAU will process claims (invoice) in accordance with the contract terms.

Budgets, Cost Reports and Supplemental Data Sheets and Claims (Invoices)
- Budgets, cost reports, supplemental data sheets, and claims (invoices) must comply with the established procedures in the State of California, Department of Mental Health, Cost Reporting/Data Collection Manual, dated July 1989.
- Quarterly Cost Reports are due by October 31, January 31, April 30.
- Year-end Cost report is due by August 31.

Submitting Claims (Invoice) for Services
Please submit all claims (invoice) for payment to:

Mental Health Services
Contract Administration Unit (CAU) (P531K)
P O Box 85524
San Diego, CA 92186-5524
Fax: (619) 563-2730, Attn: Lead Fiscal Analyst

Overpayment
In the event of overpayments, excess funds must be returned or offset against future claim payments.

Certification on Disbarment or Exclusion
Beginning April 1, 2003, all claims for reimbursement submitted must contain a certification about staff freedom from federal disbarment or exclusion from services. The details of this new procedure are laid out in the February 21, 2003, Letter from Health and Human Services Agency (HHSA) Contract Support and Compliance directed to all HHSA contractors.

In order to be in compliance with these federal regulations, all organizational providers must verify monthly the status of employee professional licenses with both the Office of the Inspector General (OIG) and Government Services Agency (GSA).

To verify through the Internet if someone is on the OIG Exclusion list or the GSA debarment list, go to:
http://oig.hhs.gov/fraud/exclusions/listofexcluded.html

To view the list of what will get someone placed on the OIG list, go to:
http://oig.hhs.gov/fraud/exclusions/exclusionauthorities.html

Please remember the following:

- Providers must retain the records verifying that these required monthly checks have been performed and the names of the employees checked.
- Any employees who appear on either the OIG or GSA lists are prohibited from working in any County funded program
- Providers are encouraged to consult with their compliance office or legal counsel should any of their employees appear on either of the exclusion lists.

License Verifications
As of July 1, 2003 all HHSA contractors are required to verify the license status of all employees who are required by the contract Statement of Work to have and maintain professional licenses. The verification must be submitted at the time of contract execution, renewal or extension. This is in accordance with the Pro Forma requirements. In order to ensure the license is valid and current, the appropriate website must be checked and documented.

SHORT-DOYLE MEDI-CAL

Per Cost Reporting/Data Collection Manual the "policy of the State Agency is that reimbursement for Short-Doyle Medi-Cal services shall be limited to the lowest of published charges, Statewide Maximum Allowances (SMA), negotiated rates or actual costs if the provider does not contract on a negotiated rate basis."

I. Definitions

Provider means the program providing the mental health services. It is part of a legal entity on file with the State Department of Mental Health.

Published Charge or Published Rate is a "term used in CFR Title 42 to define provider cost reimbursement mechanisms from third party sources. This generally means that customary charges throughout the year should be as close to actual (cost) as possible to avoid a lesser of costs or charges audit exception circumstance."

Published rates for services provided by organizational providers must be updated at the beginning of each fiscal year to ensure the County's MIS has the accurate information as well as ensuring no potential loss of Medi-Cal revenue.
The published rate for a specific service should, at a minimum, reflect the total cost for providing that service to ensure no loss of Medi-Cal revenue.
Published rates are to be submitted to United Behavioral Health and MHS CAU no later than June 14 of each year.

Statewide Maximum Allowances (SMA) are upper limit rates established for each type of service, for a unit of service. SMA is an annual rate for reimbursement of a SD/MC unit of service.

Negotiated Rate is a fixed prospective rate subject to the limitations of rate setting requirements.

Actual Cost is reasonable and allowable cost based on year-end cost reports and Medicare principles of reimbursement per 42 CFR Part 413 and HCFA Publication 15-1.

Federal Financial Participation per Title 9 CCR Chapter 11 means the federal matching funds available for services provided to Medi-Cal beneficiaries under the Medi-Cal program.

II. Medi-Cal Revenue

MIS will bill Medi-Cal for covered services provided to Medi-Cal beneficiaries by Short-Doyle Medi-Cal certified programs. For services that do not clear the billing edits, the State will issue Medi-Cal Error Correction Reports (ECRs) to the MHP's agent MH Billing Unit Fiscal Services. MN Billing Unit, who will mail the ECRs to the appropriate providers. Providers need to make the necessary corrections to the ECRs and resubmit them within ten (10) business days at the following address:

County of San Diego HHSA – Mills Bldg.
Mental Health Billing Unit Fiscal Services
1255 Imperial Ave.
San Diego, CA 92101
Attn: Fiscal Services 6th Floor Rm 633

III. *Medi-Cal Disallowance/Recoupment of Federal Financial Participation (FFP) Dollars*

Per the current California State DMH Reasons for Recoupment of FFP dollars, AMHS is obligated to disallow the Medi-Cal claim under the following categories:

- Medical Necessity

- Client Plan
- Progress Notes.

Located in *Appendix J (A.J.1)* is the complete listing of recoupment criteria based on the above categories. Organizational providers shall be responsible for ensuring that all medical records comply with federal, State and County documentation standards when billing for reimbursement of services.

The federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In accordance with State guidelines, these disallowances may be subject to future change.

Contractor shall reimburse AMHS for any disallowance of Short-Doyle/Medi-Cal payments, and reimbursement shall be based on the disallowed units of service at the Contractor's approved budgeted unit cost. The Federal share of the Medi-Cal claims for the above circumstances will be deducted from your contract payment.

In FY 04-05, the State announced that the State (non-Federal) share of EPSDT claims will also be subject to recoupment if any current or new recoupment criteria issued by the Department of Mental Health are met.

IV. *Billing Disallowances – Provider Self Report*

The policy of San Diego County Behavioral Health Services Administration (SDCBHS) is to recoup Federal Financial Participation (FFP) and Early Periodic Screening and Diagnostic Treatment (EPSDT) dollars by disallowing billing which has been identified and reported to the SDCBHS by the Contracted Organizational Providers and County Owned and Operated Clinics in accordance with documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars."

PROCEDURES

The following are the procedures to be followed for Self Reporting of Billing Disallowances to ensure consistent procedures are used when the information is reported to Behavioral Health Services Administration by providers.

Provider Requirements

1. Providers are required to conduct internal review of medical records on a regular basis (i.e. monthly) in order to ensure that the documentation meets all County, State and federal standards and that billing is substantiated.
2. If the review of a Medi-Cal client's chart results in a finding that the clinical documentation does not meet the documentation standards as set forth in the current California State Department of Mental Health "Reasons for Recoupment of Federal Financial Participation Dollars" the provider shall be responsible for addressing the issue by filing a self-report of billing disallowances with SDCMH.
3. To file a self-report of billing disallowances with SDCMH providers shall fill out one of the Provider Self-Report Billing Disallowance and Deletion forms and e-mail the form to MH Admin as directed on the form. If the service is prior to 10/1/08, they must use the InSyst form (*Appendix J - A.J.2 – Tab 1).* If the service is 10/1/08 or later, they must use the Anasazi form *Appendix J – A..J.3 – Tab 1*).
4. Providers shall ensure that the services listed on the form as disallowances are noted correctly and do not contain errors. Items that are listed on the form incorrectly are the responsibility of the provider to correct. All disallowed services must be listed on the form exactly as they were billed.
5. All services that are disallowed will also be voided from Anasazi. Providers are responsible for re-entering corrected service information for all billable and non-billable services as applicable based on the disallowance instructions (*Appendix J – A.J.2or 3 - second tab*). Services that may be corrected will be identified in the Anasazi system with a code 33. Services with a QI disallowance and disallowance for reason of 1 to 7 & 14 per disallowance instructions cannot be re-entered; these services will be identified with a code 32.
6. Providers will receive confirmation from BHS Financial Management Unit when the services have been voided and disallowed. Once confirmation is received, if applicable, see disallowance instructions and re-enter the services.
7. In order to remove billing from EPSDT review, providers must send the Provider Self-Report Disallowance and Deletion form prior to receipt of notification that an EPSDT review has been scheduled for that provider. Items received less than 21 calendar days prior to the receipt of notification that an EPSDT review has been scheduled may not be fully processed and therefore may not be removed from the EPSDT review, and may still be subject to recoupment by DMH. (Please note: There is a possible DMH update on this matter- this standard may be changed by DMH in the near future. Providers are accountable for knowing about any changes in regulations made by DMH through DMH Letters and Notices. If a change is made by DMH providers should not wait for County notice or updates to the handbook to recognize the change).

Contract Administration Unit Procedures

1. On a quarterly basis, the Contract Administration Unit staff (CAU) will prepare a letter pertaining to disallowances that will be sent to Contractors indicating that the County shall be entitled to recoup the disallowances.
2. Within 90 days of the end of the fiscal year, CAU staff will ensure that all disallowances are included in the calculation of the year-end provider payment settlement. Notices will be sent to all Contractors that are entitled to additional payment or are subject to recoupment because of overpayment to the Contractor.
3. Contractors that have been overpaid may elect to repay the recoupment via check or an offset from future payments.
   - If the contractor pays by check, the check is received by CAU staff and forwarded to Financial Management staff for deposit. The payment is logged in the contract file along with a copy of the payment.
   - If no check is received by CAU within 15 business days from the date of the letter to the Contractor; the recoupment amount is deducted from the next scheduled provider payment.

Billing Inquiries

Questions regarding claims (invoice) for payment should be directed in writing to:

Mental Health Services
Contract Administration Unit (P531K)
P O Box 85524
San Diego, CA 92186-5524
Attn: Lead Fiscal Analyst

Questions can also be addressed by calling the Lead Fiscal Analyst 619-563-2722.

County Operated Mental Health Services

County programs are required to follow county policy.

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K. PROVIDER ISSUE RESOLUTION

The MHP recognizes that at times providers may disagree with the MHP over an administrative or fiscal issue and will be happy to work with them to solve the problem. There is both an informal and formal Provider Problem Resolution Process for providers who have concerns or complaints about the MHP.

Informal Process

Providers are encouraged to communicate any concerns or complaints to the Program Monitor or designee. The Program Monitor or designee shall respond in an objective and timely manner, attempting through direct contact with the provider to resolve the issue. When issues are not resolved to the provider's satisfaction informally, a formal process is available. A copy of complaint materials will be sent to the County Mental Health QI Unit.

If the provider is not satisfied with the result or the informal process or any time, the formal process below is available:

Formal Provider Problem Resolution Process

1. Providers shall submit in writing any unresolved concerns or complaints to the MHS Contracts Manager Chief, Behavioral Health Services Contracts Support or designee, using the Formal Complaint by Provider form (located in *Appendix K- A.K.1*).
2. Written narration shall include all relevant data, as well as, attachment of any documents, which support the provider's issue(s).
3. Formal complaint shall be submitted within 90 calendar days of original attempt to resolve issue(s) informally.
4. The Contracts Manager Chief, BHS Contracts Support or designee shall have 60 calendar days from the receipt of the written complaint to inform the provider in writing of the decision, using the Formal Response to Complaint form (see *Appendix K – A.K.2*).
5. The written response from the Contracts Manager Chief, BHS Contracts Support or designee shall include a statement of the reason(s) for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Problem Resolution documentation is to be directed to:

Mental Health Services Contracts Manager Chief, BHS Contracts Support
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-K

7. A copy of all complaint materials shall be sent to the County Mental Health QI Unit.

PROVIDER ISSUE RESOLUTION

Formal Provider Appeal Process

1. Provider may submit an appeal within 30 calendar days of written decision to the Formal Complaint.
2. Formal Provider Appeals from an adult services provider shall be submitted in writing, using the Formal Appeal by Provider form (see *Appendix K – A.K.3*), to the Assistant Deputy Director (ADD) for AMHS. Formal Provider Appeals from CMHS shall be submitted in writing to the Assistant Deputy Director of CHMS.
3. The Appeal Form shall summarize the issue(s) and outline support for appeal. Previous documents on the issue(s) shall be attached.
4. The ADD shall notify the provider, in writing, of the decision within 60 calendar days from the receipt of the appeal and supporting documents, using the Formal Appeal Response Complaint Form (see *Appendix K – A.K.4*).
5. The written response from the ADD shall include a statement of the reasons for the decision that addresses each issue raised by the provider, and any action required by the provider to implement the decision.
6. Formal Provider Appeal documentation is to be directed to:

Assistant Deputy Director of
Adult Mental Health Services
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-A

Assistant Deputy Director of
Children's Mental Health Services
P.O. Box 85524
San Diego, CA 92186-5524
Mail Stop: P531-C

7. A copy of all appeals materials should be sent to the County Mental Health QI Unit:

Quality Improvement Unit
P.O. Box 85524
San Diego, CA 92186-5524
Fax: (619) 584-5018
Mail Stop: P531-Q (Children)
Mail Stop: P531-G (Adults)

Quality Improvement Process

1. The Quality Improvement Unit shall gather, track and analyze all formal provider problem resolution issues.
2. All Organizational Providers who submit a formal complaint, and/or formal appeal, shall send a copy to the Quality Improvement Unit.
3. All Program Monitors or designees, the Chief, BHS Contracts Support who obtains a formal complaint, and/or the ADD who handles an appeal shall forward a copy to the Quality Improvement Unit, attaching the response.
4. The Quality Improvement Unit will log all formal complaints and appeals as it pertains to

issue, timeline compliance, resolution disposition and action plan. This unit will identify opportunities for improvement and decide which opportunities to pursue, design and implement interventions to improve performance, and measure the effectiveness of any interventions.

Contract Administration and Fiscal Issues with MHP Contracts

Please see the Provider Contracting section of this Handbook.

PROVIDER ISSUE RESOLUTION

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L. PRACTICE GUIDELINES

Practice guidelines refer to methods and standards for providing clinical services to clients. They are based on clinical consensus and research findings as to the most effective best practices and evidence-based practices available. Because they reflect current interpretations of best practices, the guidelines may change as new information and/or technology becomes available. Special efforts must be given in respect to the unique values, culture, spiritual beliefs, lifestyles and personal experience in the provision of mental health services to individual consumers.

Treatment of Co-Occurring Substance Abuse and Mental Health Disorders

Clients with co-occurring mental health and substance use issues are common in the public mental health system and present with complex needs. Consequently, the presence of substance use should be explored with all clients and caretakers as part of routine screening at the point of initial evaluation, as well as during the course of ongoing treatment. For adults with serious mental illness who meet eligibility criteria, integrated treatment of a co-occurring substance use disorder and the mental health diagnosis is nationally recognized as evidenced based practice. Please implement the following when serving an adult client that meets the criteria for co-occurring disorders:

- Document on the Admission Checklist that the client and/or family was given a copy of your program's Welcoming Statement, if any.
- Include substance use and abuse issues in your initial screening or assessment, including the MHS-912 form as well as additional screening tools that may be adopted or required.
- For adult clients who meet the DSM-IV-TR diagnostic criteria for both a mental health and substance use disorder, the primary diagnosis shall be the covered mental health diagnosis that is the focus of treatment. This does not imply that the substance use issue is less important than or attributed to the mental health disorder.
- For adult clients who do not meet the specialty mental health medical necessity criteria, but do have an identified substance use issue, the provider will make appropriate services referrals and document actions taken.
- Substance use or abuse, including in a caretaker should be coded under the Axis IV (Psychosocial and Environmental Problems) classification and also coded in the InSyst database under the *Other Factors* code.
- In general, treatment services and documentation shall focus on the primary mental health diagnosis and the identified functional impairment(s). For adult clients, the co-occurring substance use issue may be integrated into treatment interventions in terms of how it impacts the functional impairment related to the mental health diagnosis. All prepaid treatment interventions shall focus on the mental health diagnosis.
- Documentation of treatment services and interventions must meet the federal and CCR Title 9 requirements if mental health services are to be claimed to Medi-Cal. If the substance use is in a collateral person, the progress note must focus on the impact of the substance use on the identified client.

- It is not appropriate to exclude a client from services solely because of the presence of a substance use disorder or a current state of intoxication. This decision should be made based on the client's accessibility for treatment, as well as client and provider safety concerns.

For more information, please reference HHSA's MHS Policy and Procedure: Specialty Mental Health Services for Clients with Co-occurring Substance Use Problems No: 01-02-205 This resource is available by contacting your Program Monitor.

Dual Diagnosis Capable Programs

Certain programs within the AMHS system will seek certification as Dual Diagnosis Capable or Dual Diagnosis Enhanced. These certifications refer to program and staff competence with clients with co-occurring disorders. In general, Dual Diagnosis Capable programs will welcome clients with both types of diagnosis, make an assessment that accounts for both disorders, and may provide treatment for the substance use within the context of the mental health treatment. Enhanced programs will be able to provide comprehensive, integrated treatment for both disorders. Following are the characteristics of Dual Diagnosis Capable Mental Health Programs when fully developed:

- Welcomes people with active substance use
- Policies and procedures address dual assessment, treatment and discharge planning
- Assessment includes integrated mental health/substance abuse history, substance diagnosis, and phase-specific needs
- Treatment plan: 2 primary problems/goals
- Discharge plan identifies substance specific skills
- Staff competencies: assessment, motivational enhancement, treatment planning, continuity of engagement
- Continuous integrated case management/phase-specific groups provided: standard staffing levels.

For participating programs, the following describes criteria for these characteristics in AMHS programs. These criteria will become more demanding as the system develops its capability.

- The program's Administrator has signed the CCISC Charter
- The program has self-surveyed by annual use of the COMPASS survey
- The program has developed an action plan after completing the COMPASS, which incorporates:
  - ✓ Screening
  - ✓ Assessment
  - ✓ Treatment Plan
  - ✓ Progress Notes
  - ✓ Discharge summary

  - ✓ Medication planning when appropriate
  - ✓ Referrals
- The program has identified leads responsible for implementation of Dual Diagnosis Capability
- The program's CADRE staff are available for trainings
- Each clinician has completed the CODECAT
- The program has developed Mission and/or Welcoming Statements that reflect dual diagnosis capability
- The program has a Policy and Procedure to support Mission and Welcoming statements, including visible materials such as posters and referral brochures
- The program routinely reports dual diagnosis clients in InSyst in the diagnosis, where appropriate, and in the Other Factor codes.

Drug Formulary for HHSA Mental Health Services

All contracted provider programs and physicians shall adopt the Medi-Cal Formulary as the San Diego County Mental Health Services (MHS) formulary. All clients, regardless of funding, must receive appropriate and adequate levels of care at all MHS programs. This includes the medications prescribed. The guidelines below allow for clinical and cost effectiveness.

The criteria for choosing a specific medication to prescribe shall be:

1. The likelihood of efficacy, based on clinical experience and evidence-based practice
2. Client preference
3. The likelihood of adequate compliance with the medication regime
4. Minimal risks from medication side-effects and drug interactions

If two or more medications are equal in their satisfaction of the four criteria, choose the medication available to the client and/or the system at the lowest cost. Programs shall provide information to all appropriate staff as to the typical cost for all drugs listed on the Medi-Cal Formulary, at least annually.

For all initial prescriptions, consideration should be given to prescribing generic medication rather than brand name medication unless there is superior efficacy for the brand name medication or the side-effect profile favors the brand name medication.

Providers shall follow the requirements for preparing a Treatment Authorization Request (TAR) as stated in the Medi-Cal Drug Formulary.

- County-operated programs shall send TARs to the County Pharmacy for any non-formulary medication.

- Contractor operated programs shall develop an internal review and approval process for dispensing non-formulary medication for both Medi-Cal and non-Medi-Cal eligible clients.

There shall be an appeal process for TARs that are not accepted.

Client/Family Education Program

Client and family education and involvement with treatment are essential to achieving successful outcomes. A Road Map to Recovery client/family education/program exists for this purpose. A complete description of this effective client and family education program can be found in the Road Map to Recovery (R2R) Handbook. The R2R Handbook is available by contacting MH Administration at (619) 563-2771.

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Diagnosis Practice Guidelines for the Electronic Health Record

Purpose

This practice guideline establishes specific procedures related to adding and changing diagnoses for the first 12 months after conversion from InSyst to Anasazi. After the first year the procedures will be reevaluated and adjusted as indicated. As part of the transition of the Mental Health Management Information System (MIS) from InSyst to Anasazi, there will be a single diagnostic profile for each client utilized across all programs. The diagnostic profile may include as many diagnoses on each axis as clinically indicated. It is expected that a single diagnostic profile will enhance the quality of care provided to clients and is the foundation of the new clinical electronic health record (EHR). This practice guideline establishes procedures for using the diagnostic profile in the Anasazi system.
Please note: It is expected that a revised Guideline may be published in the near future. Please follow this policy until notified by SDCMHS.

Background

InSyst required that a client's diagnostic profile be recorded for each admission and discharge to a specific program. Clients served by multiple programs could have several diagnostic profiles in effect at any given time.

As part of the transition from multiple diagnostic profiles in InSyst to the single diagnostic profile in Anasazi, only diagnostic data for each client's most recently opened episode/program is converted.

Practice Guideline

This practice guideline establishes specific procedures related to adding and changing diagnoses for the first 12 months after conversion from InSyst to Anasazi. After the first year the procedures will be reevaluated and adjusted as indicated.

Each program is responsible for ensuring that the diagnoses being treated at their program are included on the client's diagnostic profile (Diagnosis Form/Screen). After data conversion, all programs shall verify that the diagnosis in the client's paper medical record matches the diagnosis in the Anasazi system. When multiple outpatient programs are concurrently providing services to a client, they are encouraged to communicate about diagnosis, treatment plans, and services for the client. A Single Accountable Individual (SAI), similar to a Care Coordinator, is automatically assigned in Anasazi based on priorities set by SDCMHS MIS. The SAI will receive notifications of when reviews are due, will communicate with concurrent providers and will facilitate updating the EHR.

I. Organizational Provider

A. Axis I and Axis II shall be completed on the Diagnosis Form by clinicians when it is within their scope of practice. When there is an existing Diagnosis Form in the EHR that does not include the diagnoses being treated by a program, that program shall add each diagnosis to the EHR with the actual date that the diagnosis was made. When there is no existing Diagnosis Form in the EHR the Diagnosis Form must be completed with a mental health diagnosis on either Axis I or Axis II that has a begin date before or equal to the first date of service. Axis I and Axis II shall not be left blank in order to show that each Axis was considered. When there is no diagnosis on Axis I or Axis II, V71.09 is used. When the diagnosis is deferred on Axis I or Axis II, 799.9 is used and can be ended with a more specific diagnosis added at any time. Other diagnoses may not be ended unless all programs concurrently serving the client agree. When it is not within a clinician's scope of practice to diagnose on Axis I and Axis II, a diagnosis may be used from an "External Provider". (See below)

B. Either Axis I or Axis II must be identified as the Primary Axis for Mental Health programs. The diagnosis on the Primary Axis can be 799.9 for only the first 30 day assessment period. If planned services other than assessment begin prior to the end of the assessment period, the799.9 diagnosis shall be ended and a definitive diagnosis added to the identified Primary Axis (Axis I or Axis II). The Primary Axis for Edgemoor may be Axis III.

C. Within each Axis (Axis IIV), the diagnosing clinician assigns a priority to each diagnosis, similar to the concept of primary and secondary diagnoses in InSyst. When diagnoses are

being added to an existing EHR they will be given the next priority on that Axis (based on Begin Date), since treatment is not affected by priorities.

D. When it is within the clinician's scope of practice to diagnose on Axis III, the clinician may enter a diagnosis on Axis III (medical condition). When it is outside of the clinician's scope of practice to diagnose on Axis III, the clinician shall leave Axis III blank. 799.9, Deferred Diagnosis, is not used on Axis III.

E. The clinician must complete the "General Medical Condition Summary Code" field on the Diagnosis Form with any medical condition(s) as reported by the client or as obtained from another medical record. In addition, the clinician shall identify in the "Comments" field the source of the medical condition(s) either as reported by the client or as obtained from another medical record. Note: When a reported medical condition is not one of the listed "General Medical Conditions", it can be recorded in the "Comments" section.

F. When a trainee completes the Diagnosis Form the co-signature of his/her licensed supervisor is required.

G. Clients seen at or admitted to EPU, ESU, UCSD CAPS, SDCPH, or a START program may have an existing Diagnosis Form in the EHR. A diagnosis may be added for the client at the time of admission/discharge. Outpatient providers shall not change a client's diagnostic profile when the client is in a 24 hour/emergency program. The EPU, ESU, UCSD CAPS, SDCPH, and START programs may end a diagnosis in order to avoid adding a mutually exclusive or conflicting diagnosis to the client's diagnostic profile (e.g., Major Depressive Disorder, Moderate vs. Major Depressive Disorder, Severe). Upon the client's return to his/her outpatient provider the SAI shall review the 24 hour/emergency provider's diagnosis and determine if the diagnosis needs to be ended or updated.

II. External Provider

A. When it is not within a clinician's scope of practice to enter a diagnosis on Axis I and Axis II, the clinician may use a diagnosis (Axis I through Axis V) from an "External Provider". A diagnosis from an External Provider is only used when there is no other active diagnosis form in the client's EHR. An External Provider is a licensed clinician/doctor who has completed an assessment of the client within the past 12months and who is outside the mental health organizational provider network. Examples include a Fee For Service (FFS) psychiatrist/psychologist or a provider outside of San Diego County.

B. The clinician completes the "External Provider" fields on the form. The clinician then completes Axis I through Avis V, as provided by the External Provider, the General Medical Conditions Summary Code, the Primary Axis, and the Trauma question.

C. If the External Provider only submitted a diagnosis on one Axis (Axis I or Axis II), the other Axis (Axis I or Axis II) shall be completed with the code 799.9, Deferred Diagnosis. If the External Provider does not provide a diagnosis on Axis III, Axis III is left blank. The clinician then completes Axis IV and Axis V on the Diagnosis Form. The clinician explains in the "Comments" field which Axis(es) he/she diagnosed.

D. When the Administrative Services Organization (ASO) authorizes services for a FFS provider and there is no active Diagnosis Form in the client's EHR, the ASO will complete the External Provider fields. A diagnosis of 799.9, Deferred Diagnosis, on Axes I and II may be used until a specific diagnosis is received with the claim from the FFS provider. The ASO will also complete the General Medical Condition Summary, select the Primary Axis, complete Axis V (GAF), and answer the Trauma Question.

PRACTICE GUIDELINES

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M. STAFF QUALIFICATIONS

Each provider is responsible for ensuring that all staff meets the requirements of federal, State, and County regulations regarding licensure, training, clinician/client ratios and staff qualifications for providing direct client care and billing for treatment services. Documentation of staff qualifications shall be kept on file at the program site. Provider shall adhere to staff qualification standards and must obtain approval from their Program Monitor or designee for any exceptions.

Provider shall comply with the licensing requirements of the California Welfare and Institutions Code Section 5751.2. Provider shall have on file a copy of all staff licenses and ASW/IMF certificates of registration with the Board of Behavioral Sciences. For staff positions requiring licensure, all licenses and registrations must be kept current and be in active status in good standing with the Board of Behavioral Sciences.

Staffing

Commensurate with scope of practice, mental health and rehabilitation services may be provided by any of the following staff:

- Physician
- Licensed/Registered/Waivered Psychologist
- Licensed/Registered/Waivered Clinical Social Worker
- Licensed/Registered/Waivered Marriage and Family Therapist
- Registered Nurse
- Licensed Vocational Nurse
- Psychiatric Technician
- Mental Health Rehabilitation Specialist *(see definition below)*
- Staff with a bachelor's degree in a mental health related field (see supervision and co-signature requirements)
- Staff with two years of full-time equivalent experience (paid or unpaid) in delivering mental health services (see supervision and co-signature requirements)
- Staff without bachelor's degree in a mental health field or two years of experience (see supervision and co-signature requirements)

Source of Information: Short Doyle/Medi-Cal Manual for the Rehabilitation Option and Targeted Case Management, Revised 7/1/95.

- ***Mental Health Rehabilitation Specialist (MHRS).*** A mental health rehabilitation specialist is an individual who has a baccalaureate degree and four years of experience in a mental health setting as a specialist in the fields of physical restoration, social adjustment, or vocational adjustment. Up to two years of graduate professional education

may be substituted for the experience requirement on a year-for-year basis. Up to two years of post associate arts clinical experience may be substituted for the required educational experience (as defined in Title 9) in addition to the requirement of four years of experience in a mental health setting.

Professional Licensing Waiver Guidelines -Welfare and Institutions Code (W&IC) Section 5751.2.

The W&IC Section 5751.2 (a): States that except as provided in this section, persons employed or under contract to provide mental health services pursuant to this part shall be subject to all applicable requirements of law regarding professional licensure, and no person shall be employed in local mental health programs and provide services for which a license is required, unless the person possesses a valid license.

- This applies to all psychologists, clinical social workers or marriage and family therapists employed by, or under contract to local mental health programs.
- This applies to both county employees and contract providers.
- This applies regardless of payer source.
- This does not apply to persons employed by or under contract to health facilities licensed by the California Department of Public Health. Waiver requests for these persons should be directed to the California Department of Public Health.
- The phrase "Mental Health Services" in this section refers to those types of treatment and services that require the practitioner to hold a license.

The W&IC Section 5751.2 (b): States that persons employed as psychologists and clinical social workers, while continuing in their employment in the same class as of January 1, 1979, in the same program or facility, including those persons on authorized leave, but not including intermittent personnel, shall be exempt from the requirement of subdivision (a).

- In order to qualify under this section, an individual would need to be employed in the same position and facility in which she/he was employed on January 1, 1979. There are probably only a few, if any, persons Statewide still in this category.

The W&IC Section 5751.2 (c): States that while registered with the licensing board of jurisdiction for the purpose of acquiring the experience required for licensure, persons employed or under contract to provide mental health pursuant to this part as clinical social workers or

marriage, family, and child counselors shall be exempt from subdivision (a). Registration shall be subject to regulations adopted by the appropriate licensing board.

- Licensed Clinical Social Worker (LCSW) and Licensed Marriage and Family Therapist (LMFT) candidates do not need a waiver, nor can one be obtained. (See the exception to this statement under Section 5751.2 (e) below for license-ready persons recruited from outside California.)

- Each LCSW and LMFT candidate is to remain registered with her/his licensing board until such time as the candidate is licensed. As stated in the statute, such registration shall be subject to the regulations adopted by the appropriate licensing board.

- The candidate must remain registered even though he/she is no longer accumulating qualifying hours.

The W&IC Section 5751.2 (d): States the requirements of subdivision (a) shall be waived by the department for persons employed or under contract to provide mental health services pursuant to this part as psychologists who are gaining the experience required for licensure. A waiver granted under this subdivision may not exceed five years from the date of employment by or contract with, a local mental health program for persons in the profession of psychology.

- Each psychologist candidate must obtain a waiver - even if he/she is registered with his/her licensing board.

- In order to be eligible for such a waiver, the psychologist candidate must have successfully completed 48 semester/trimester or 72 Quarter units of graduate coursework, not including thesis, internship or dissertation. An official copy of a transcript reflecting completion of this coursework requirement must be submitted with the waiver application.

- There is no statutory provision for extension of psychologist candidate waivers beyond the five year limit.

The W&IC Section 5751.2 (e): States the requirements of subdivision (a) shall be waived by the department for persons who have been recruited for employment from outside the state as psychologists, clinical social workers, or marriage, family, and child counselors whose experience is sufficient to gain admission to the licensing examination. A waiver granted under this subdivision may not exceed three years from the date of employment by or contract with, a local mental health program for persons in these three professions who are recruited from outside the state.

- To be eligible, the psychologist, LCSW, or MFT candidate must be recruited from outside California and have sufficient experience to gain admission to the appropriate licensing examination. For applicants in this category, a letter from the appropriate California licensing board which states the applicant has sufficient experience to gain admission to the licensing examination must be included with the waiver application.

The following general points should be noted:

- Mental Health Plans (MHPs) should submit and receive approval for waivers under subdivisions 5751.2 (d) [psychologist candidates] and 5751.2 (e) [candidates recruited from outside California whose experience is sufficient to gain admission to the appropriate licensing examination] *prior to allowing candidates to begin work for which a license waiver is required.*

- Waivers are not transferable from one MHP to another. If an individual who obtained a waiver while working for one MHP terminates employment and is subsequently hired by a second MHP, an application for a new waiver must be submitted by the second MHP prior to allowing the candidate to begin work for which a license or waiver is required.

- Once a waiver is granted, the waiver period runs continuously to its expiration point unless the MHP requests that it be terminated earlier.

Use the "Mental Health Professional Licensing Waiver Request" form (and instruction sheet) included in ***(Appendix M – A.M.1).*** Please review the instructions prior to faxing the waiver requests to QI Unit, Attn: Waiver Requests at (619) 563- 2795 or e-mail documents to ian.rosengarten@sdcounty.ca.gov. For additional questions, please contact your QI Specialist.

Documentation and Co-Signature Requirements

AMHS staff that provide mental health services are required to adhere to certain documentation and co-signature requirements. For the most current information on co-signature requirements, please refer to the Adult Documentation and Uniform Clinical Record and Manual. This manual will instruct staff on form completion timeframes, licensure and co-signature requirements, and staff qualifications necessary for completion and documentation of certain forms.

In general, staff that hold the license of an M.D., R.N., Ph.D., LCSW, or MFT do not require a co-signature on any documentation in the medical record. In addition, the same holds true for staff that are registered associates or interns (ASW or IMF) with the Board of Behavioral Sciences (CA) or waivered according to State guidelines. These above referenced staff may also

provide the co-signature that is required for other staff. Staff that does not meet the minimum qualifications of an MHRS shall have adequate clinical supervision and co-signatures from a licensed/registered/waivered staff.

In the Documentation and Uniform Clinical Record Manual, there are specific forms for Mental Health Assessments, Client Plan, and Discharge Summary that require the signature of a licensed/registered/waivered staff member. If the staff completing the form is not licensed/registered/waivered, then a co-signature by a licensed/registered/waivered staff is required. These forms have specific time requirements which affect compliance with regulations and recoupment of FFP dollars. In order to be in compliance and not risk recoupment of FFP dollars, all required co-signatures must be signed within the required time frame. Following is a brief summary chart, which indicates in general, documentation and co-signature requirements. For additional questions, please contact your Adult QI Specialist.

STAFF DISCIPLINE	**CO-SIGNATURE REQUIREMENTS** (From Documentation and Uniform Clinical Record Manual)			
YES = REQUIRES A CO-SIGNATURE **NO** = NO CO-SIGNATURE REQUIRED **N/A** = CREDENTIAL CANNOT PROVIDE SERVICE	Initial Assessment, Mental Health Assessment Update, and Expedited Assessment	Client Plan	Discharge Summary	Progress Notes
M.D.	NO	NO	NO	NO
R.N.	NO	NO	NO	NO
LICENSED/REGISTERED/WAIVERED PH.D, LCSW, MFT	NO	NO	NO	NO
LICENSED VOCATIONAL NURSE	N/A	N/A	N/A	NO
PSYCHIATRIC TECHNICIAN	N/A	N/A	N/A	NO
MENTAL HEALTH REHAB SPECIALIST (MHRS)	YES	YES	YES	NO
STAFF NOT MEETING THE MINIMUM QUALIFICATIONS FOR AN MHRS	N/A	N/A	N/A	YES

Staff Supervision Requirements

- Programs must provide supervision in amount and type that is adequate to insure client

safety, maximize gains in functioning, and meet the standards of the professions of those staff employed in the program.

• Programs who employ waivered/registered staff receiving supervision for licensure must offer experience and supervision that meet the requirements of the licensing board to which the person is registered.

• Programs must provide adequate training, supervision, and co-signatures by a licensed/registered/waivered staff for staff that does not meet the minimum qualifications of an MHRS.

Staffing Requirements

• All providers shall have staff in numbers and training adequate to meet the needs of the program's target population.

• Psychiatry time: Outpatient programs must also have psychiatry time sufficient to allow the psychiatrist's participation in treatment reviews, especially where medications may be discussed, plus adequate time per month for new client assessments and medication followed up.

• For programs certified to provide Medi-Cal/Short Doyle mental health services, the Head of Service (Program Manager) providing clinical direction must be licensed. If the Program Manager is not licensed, there must be a Clinical Lead who can provide clinical supervision and perform certain tasks, such as diagnosing, that are within the scope of practice of licensed and waivered persons.

Use of Volunteers and Interns

• Provider shall utilize family and community members as volunteers in as many aspects of the programming as possible, including teaching a special skill and providing one-on-one assistance to clients. Particular emphasis shall be made to recruit volunteers from diverse communities within program region.

• Provider shall have policies and procedures surrounding both the use of volunteers and the use of employees who are also clients.

• Licensed staff shall supervise volunteers, students, interns, mental health clients and unlicensed staff involved in direct client care.

STAFF QUALIFICATIONS AND SUPERVISION

N. DATA REQUIREMENTS

Data Collection and Retention

Contractor shall maintain daily records of services provided, including dates of service, times of service, total time of service, types of services provided, persons served, and progress of clients in meeting the objectives of the case plan. Data shall be recorded in accordance with the specifications in the Anasazi User's Manual. Service entry shall be kept up to date and the data shall be entered into the SDMHS MIS (Anasazi) within two business days of service delivery.

Accuracy of Data

Providers are responsible for ensuring that all client information is accurate including addresses and all demographic data that is required for State reporting for Client Statistical Information (CSI). Providers must have processes in place for checking/updating client data and making the necessary corrections.

Full Service Partnership programs are required to ensure that all required data that are to be tracked for their clients are correct and up-to-date in both the MH MIS and State Databases.

Financial Eligibility and Billing Procedures

Each provider is responsible for specific functions related to determining client financial eligibility, billing and collections. The **Financial Eligibility and Billing Procedures - Organizational Providers Manual** is available on the UBH Public Sector website (https://www.ubhonline.com/publicSector/) for providers as a guide for determining financial eligibility, billing and collection procedures. This manual includes the following procedure categories:

- Determining financial eligibility
- Billing, collections and payment procedures
- Corrections, adjustments and special requirements

This manual is not intended to replace the Anasazi Users Manual or intended to be a comprehensive "Insurance and Medicare Billing" guide. It is meant to augment existing resource materials.

Medi-Cal Administrative Activities (MAA)

Federal and State regulations (Welfare and Institutions Code, Section 14132.47, Medi-Cal Administrative Activities) permit counties to earn federal Medi-Cal reimbursement for activities that are necessary for the proper and efficient administration of a State's Medicaid (Medi-Cal) plan. These MAA activities are focused on assisting individuals to access the Medi-Cal Program and the services it covers through such functions as Medi-Cal and mental health outreach,

facilitating Medi-Cal eligibility determinations, MAA coordination and claims activities and other designated activities.

Organizational providers may be permitted to provide MAA services and claim them.. The MHP requires that each organizational provider have a County approved MAA Claiming Plan prior to claiming MAA services, and that each provider complies with all applicable State and federal regulations. To claim for MAA activities, a provider must follow a set of procedures, which are described in detail in the *MAA Instruction Manual* developed by the State Department of Mental Health.

To assist providers, AMHS offers technical assistance and training on MAA through the MAA Coordinator. The MAA Coordinator can provide assistance with claiming and procedural questions or provide a MAA training to staff.

Included in *Appendix N (A.N.1)* is a Medi-Cal Administrative Activities Procedures Handout for providers claiming MAA activities with an approved MAA claiming plan. This handout may be used for reference and training purposes.

Additional Outcome Measures

Additional statistical data may be required in your specific contract. This may involve the use of additional tools for Evidence Based Programs or for specific parts of the system. Your contract may also require manual collection of data on certain outcomes from client charts, such as number of hospitalizations, readmissions, arrests, or changes in level of placement/living situation. The data collected should be submitted on your MSR or as directed by your Program's COTR or AMHS QI unit.

O. TRAINING/TECHNICAL ASSISTANCE

The Quality Improvement Unit provides training and technical assistance on topics related to the provision of services in the Adult/Older Adult Systems of Care.

Training and information is disseminated through:

- Documentation and Uniform Clinical Record Manual Training
- Anasazi training
- QI In-Service Trainings
- "What's New In QI" – QI Bulletin
- Organizational Provider Operations Handbook
- Regular Provider Meetings.

For information on upcoming trainings or in-services, or if you require technical assistance, please contact the:

Quality Improvement Unit
P.O. Box 85524
San Diego, CA 92186-5524
MS: P531-G

Other Training

The HHSA Training and Development department publishes a monthly calendar of clinical trainings that are available to organizational contracted providers. Behavioral Health Education and Training Academy (BHETA) is a county contract program that also provides trainings. Please note there may be a fee for these trainings. Please contact your organization's training liaison directly for information on training, registration, and fees.

TRAINING/TECHNICAL ASSISTANCE

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P. AB 2726 SERVICES FOR ADULTS 18-22

This section provides the treatment and documentation protocol for adult mental health programs that will begin treating or are currently treating adult clients (between 18-22) who are currently receiving mental health services through AB2726 and are transitioning from the children's mental health system via a referral from the current children's mental health provider to the new adult mental health provider.

Assembly Bill 2726

AB 2726 (Assembly Bill 2726; also known as AB3632) is a program designed to provide educational mental health services to special education students who need the services to benefit from their education. These services are listed on the students' Individualized Education Plan (IEP) and can be provided for adult clients between 18 and 22 years of age who are still participating in a high school program. The students must have a mental health issue that affects their educational performance, or impedes them from benefiting from educational services, and who do not respond to counseling provided by the school. The educational mental health services are identified on the student's Individualized Education Plan (IEP). The major service delivery models used are Outpatient Therapy, Day Treatment and Residential Care. The County of San Diego's Special Education Services (SES) program provides assessment, re-assessment and case management services for these identified clients. The SES program provides regionalized services and has Central and North County office locations.

Referrals to the County of San Diego's SES program can be from school staff or parents. Once a referral is received, an SES case manager is assigned to complete a multi-faceted assessment, within mandated timelines, to determine eligibility for AB2726 services. If the case manager recommends outpatient therapy through AB2726, the services are added to the student's IEP. A Mental Health Treatment Plan is completed and the referral is forwarded to an outpatient provider. The SES case manager then closes the case in their program, and the outpatient clinician provides the special education services, as per the IEP and the Mental Health Treatment Plan.

Although the majority of AB2726 clients are children and adolescents served in the Children's Mental Health System, there are adult AB2726 clients that are between the ages of 18 and 22 years of age, who are still participating in a high school program, that are served in the Adult Mental Health System. Providers must follow the specified regulations for all AB2726 clients as outlined below.

AB 2726 SERVICES FOR ADULTS 18-22

Outpatient Standards for Adult AB2726 Clients

Outpatient service requirements for standards of practice with regard to provider/school interactions on behalf of Adult AB2726 students have been established and are to be documented in the medical record as follows:

- Timeline for Intake within 7-10 calendar days

- Upon receipt of assignment the clinician shall contact the school contact person

- A face-to-face contact between the therapist and school person (teacher or other designated contact person) within the first 60 (sixty) days of treatment

- A minimum of monthly contact with the school contact thereafter to include discussion regarding medication effectiveness as well as academic status and behavioral management

- A home visit by the therapist during the course of treatment. Exception shall include justification in the medical record as to why a home visit is not clinically indicated. *(Justification for exception of the home visit for existing clients who have been in treatment a year or more may be the length of time they have been in treatment already and the move toward termination).*

- Attendance of therapist, or knowledgeable representative from the mental health program, at IEP meetings when a major educational placement change may occur, annual review and at the end of treatment.

- Quarterly Progress Mental Health IEP Reports shall be submitted to the client/parent and the teachers—(refer to Mental Health IEP Reporting section below)

- Comply with timelines for Requests for Information and Records. Under the Individuals with Disabilities Education Act, pupil records are subject to the federal FERPA and state pupil records provisions, including state rules on providing copies to parents. All AB2726 parent/client requests for pupil records are to be completed and delivered to the parent/client within 5 (five) calendar days. Any request for release of pupil records must be accompanied by a signed authorization for release of those records.

Mental Health IEP Reporting

- The outpatient clinician shall contact the student's teacher monthly to discuss progress and concerns. This contact shall be recorded in the client's medical record.

- The outpatient clinician shall submit the "Quarterly Progress Mental Health IEP

Report" (instruction sheet (*A.P.1)* and form *(A.P.2)* located in *Appendix P*) to the client and school contacts on a quarterly basis. This report shall document the student's progress on the Mental Health IEP goals addressed through outpatient services. A copy of this report shall be maintained in the client's medical record.

• The outpatient clinician shall coordinate the AB 2726 outpatient mental health services with all other counseling services the student is receiving that are documented on the IEP. Evidence of such service coordination shall be documented in the client's medical record.

• The outpatient clinician shall update the "Mental Health Treatment Plan" (instruction sheet *(A.P.3)* and Plan *(A.P.4)* located in *Appendix P*) at the Benchmark/Short Term Objective time frames listed on the form. Clinician shall complete an updated "Mental Health Treatment Plan" every six months, and request an IEP meeting for IEP team to review and accept updated plan.

Note: to reconvene an IEP meeting, the outpatient provider completes the "Need for IEP Review" form (instruction sheet (*A.P.5)* and form *(A.P.6)* located in *Appendix P*) and forwards it to the school contact. Please note that the Clinician needs all signed, updated IEP's to maintain in client's medical record.

Undocumented Adult AB 2726 Clients

Immigration status has been concluded to play no role in determining whether a school district is responsible for educating a student. Therefore, immigration status shall not be taken into consideration for students between 18 and 22 years of age who are still participating in a high school program and require mental health services pursuant to their Individualized Education Plan (IEP). Undocumented adult AB 2726 students shall receive appropriate mental health services as outlined in their IEP.

Medication Monitoring for AB 2726 Clients

Medication evaluation and/or medication management services are provided under the required provisions of the AB 2726 program and are at no cost to the client/parent (Section 60020, Education Code; Section 7587, Government Code). The medication itself is not a benefit covered by the AB 2726 program nor does the County incur this service or cost.

The following are some general guidelines to assist clients and families in obtaining assistance with medication and laboratory costs:

<u>IF CLIENT HAS MEDI-CAL</u>
Program psychiatrist can write a prescription and have the client fill it at a Medi-Cal participating pharmacy, as is the current procedure.

IF CLIENT HAS HEALTHY FAMILIES

Program staff, clinician, or psychiatrist should work with the client's physician to see if they will provide medication if provided with a consultation or psychiatric evaluation by the program psychiatrist. Providers should be aware that Healthy Families may refer the student back to County Mental Health for an assessment. If this occurs and the client is diagnosed with a Severe Emotional Disturbance (SED), then the program would be responsible for medication under the Healthy Families carve-out.

IF CLIENT/FAMILY HAS PRIVATE INSURANCE

Refer to services covered by family's private insurance plan.
(Parents/Clients with private insurance coverage will be helped by the passage of The Mental Health Parity Law (AB 88). AB 88 requires most California health care plans to cover the diagnosis and medically necessary treatment of serious mental illness and emotional disturbances of a child on terms equal to their health plan medical coverage.)

IF CLIENT'S/FAMILY'S PRIVATE INSURANCE HAS NO MENTAL HEALTH BENEFIT

Program should verify with insurance plan if mental health is a covered benefit due to the Mental Health Parity Law (AB88). Mental health program psychiatrists may be able to provide sample medications or work with the client's physician to see if they will provide medication if provided with a consultation or psychiatric evaluation by the program psychiatrist.

IF CLIENT IS INDIGENT

Every effort must be made to link the family to other resources in the community.

Program psychiatrists may be able to provide sample medications or work with the client's physician to see if they will provide medication if provided with a consultation or psychiatric evaluation by the program psychiatrist.

Program can provide financial screening to determine the annual client liability for mental health services using the "Uniform Method for Determining Ability to Pay" (UMDAP) method. Following the financial screening, the Program Manager must approve all clients who will be receiving medication through the program.

Discharge for Adult AB2726 Clients

1. Discharge may occur when a student is ready to leave the outpatient program because:

    a. they have met their mental health IEP goals
    b. a change in the mental health level of care is needed
    c. the client is refusing services

Note: Any and all changes must be reviewed by the IEP team members, which include at a minimum, the outpatient clinician, the district of residence, and the client. Some changes in

the level of care may require a request for reassessment through the IEP process.

2. The program will coordinate discharge planning with the school district liaison(s) before providing any specific information to the client.

3. Discharge recommendations regarding level of care will be developed in accordance with AB2726 guidelines and may require a request for reassessment through the IEP process.

4. Discharge summaries shall clearly address student progress on IEP goals and other treatment issues.

5. When a student is transferring from one outpatient program to another, the student may not be discharged from the sending program until he/she has been admitted to the new program. The outpatient clinician shall make certain that there is connection to the new program. This includes ensuring outpatient mental health services on the IEP are changed from the sending school district to the receiving school district.

6. Programs shall not discharge a student without requesting an IEP review. Stay put orders apply in cases of Due Process.

7. Notify the regional Mental Health Special Education services program manager in writing when there are critical problems related to IEP (e.g. client fails to start treatment).

8. Regional Mental Health Special Education Services program managers:

North Coastal/Poway
Program Manager
340 Rancheros Dr., Suite 298
San Marcos, CA 92069
(Tel.) 760-752-4900
(Fax) 760-752-4924

North Inland/East Region
Program Manager
3692 Midway Drive
San Diego, CA 92110
(Tel.) 619-758-6240
(Fax) 619-758-6250

South/Central Region
Program Manager
3320 Kemper St., Suite 104
San Diego, CA 92110
(Tel.) 619-758-6205
(Fax) 619-758-6209

Administration
3320 Kemper Street, Suite 206
San Diego, CA 92110
(Tel.) 619-758-6227
(Fax) 619-758-6255

AB 2726 SERVICES FOR ADULTS 18-22

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Q. QUICK REFERENCE

PHONE DIRECTORY

ACCESS AND CRISIS LINE	**1-800-479-3339**
COUNTY OF SAN DIEGO MHP ADMINISTRATION	**(619) 563-2700**
Local Mental Health Director	(619) 563-2700
Medical Director	(619) 563-2700
Director, Quality Improvement Unit	(619) 563-2754
Program Manager, Adult Quality Improvement Unit	(619) 563-2747
Serious Incident FAX	(619) 563-2795
Adult Service Intake/Triage Log FAX	(619) 563-2799
Contract Administration Unit Manager	(619) 563-2733
Claim Submission FAX	(619) 563-2730
MHP Compliance Hotline	(866) 549-0004
MAA Coordinator	(619) 563-2700

ADMINISTRATIVE SERVICES ORGANIZATION for SAN DIEGO MHP

United Behavioral Health, San Diego	
Provider Line	1-800-798-2254
UBH Administrative Services for MHP	(619) 641-6800
Director, Regulatory and Provider Services	(619) 641-6806
MIS Help Desk	(800) 834-3792
FAX MIS Finance	(619) 641-6975
Clinical-Access and Crisis Line	(619) 641-6802
Regulatory &Provider Services	(619) 641-6979

CLIENT ADVOCACY ORGANIZATIONS

Consumer Center for Health Education and Advocacy	1-877-734-3258
JFS Patient Advocacy Program	1-800-479-2233
Deaf Community Services	1-800-290-6098
Interpreters Unlimited	1-858-451-7490

WORLD WIDE WEB RESOURCES

County of San Diego	www.sdcounty.ca.gov
United Behavioral Health (UBH)	www.ubhpublicsector.com
California Board of Behavioral Sciences	www.bbs.ca.gov
California Board of Psychology	www.psychboard.ca.gov
California Code of Regulations	www.calregs.com
California Department of Mental Health	www.dmh.ca.gov
California Medi-Cal Website	www.medi-cal.ca.gov
California Mental Health Directors Association	www.cmhda.org

QUICK REFERENCE

California Welfare & Institutions Code	www.leginfo.ca.gov/calaw.html
Center for Medicare and Medicaid Services	www.cms.hhs.gov
Community Health Improvement Partners	www.sdchip.org
Disability Benefits 101	www.disabilitybenefits101.org
Inform San Diego (Social Services Database)	www.informsandiego.com
211 San Diego (Social Services Database)	www.211sandiego.org
Intentional Care Website	www.intentionalcare.org
International Association of Psychosocial Rehabilitation Services (IAPSRS)	www.iapsrs.org
Joint Commission on Accreditation of Healthcare Organizations	www.jcaho.org
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
Network of Care	www.networkofcare.org
Office of Inspector General Exclusion List	www.oig.hhs.gov
GSA Excluded Parties Listing System (debarment)	http://epls.arnet.gov
Social Security Online	www.socialsecurity.gov or www.ssa.gov
Ticket to Work Program	www.yourtickettowork.com

R. MENTAL HEALTH SERVICES ACT - MHSA

After California voters passed Proposition 63 in November 2004, the Mental Health Services Act (MHSA), became effective January 1, 2005. The purpose of the act was to expand mental health service funding to create a comprehensive community based mental health system for persons of all ages with serious and persistent mental health problems. The MHP has completed its initial extensive community program planning process and has secured a state approved Community Services and Supports Plan. The next phases of enactment of the MHSA will include funding for prevention/early intervention, innovations, capital facilities and technology, and education and training.

MHSA System Transformation

Under the MHSA, community based services and treatment options in San Diego County are to be improved, expanded, and transformed by:

1. Increasing Client and Family Participation
2. Serving More Clients
3. Improving Outcomes for Clients
4. Decreasing Stigmatization
5. Minimizing Barriers to Services
6. Increasing Planning and Use of Data
7. Increasing Prevention Programming
8. Including Primary Care in the Continuum of Care
9. Using of Proven, Innovative, Values-Driven and Evidence-Based Programs

As a result of expanded funding, the MHSA will hold counties accountable for a number of outcomes. The outcomes include decreases in racial disparities, hospitalizations, incarcerations, out-of-home placements and homelessness while increasing timely access to care. Other outcomes may be required as the State and County evaluate the start-up of MHSA services. Contractors receiving MHSA funding will be responsible for complying with any new MHSA requirements.

MHSA Full Service Partnerships

A number of providers will be participating in MHSA Full Service Partnerships, which both provide mental health services to clients and link them with a variety of community supports, designed to increase self sufficiency and stability. These providers are required to participate in a State data collection program which tracks initial, specialized client assessments, ongoing key incident tracking and quarterly assessments. The State has set timeframes for provisions of each type of data.

MENTAL HEALTH SERVICES ACT - MHSA

For current information on MHSA, visit www.sandiego.networkofcare.org/mh . For current State level and general MHSA information, visit www.dmh.cahwnet.gov/Prop_63/MHSA/default.asp or call (800) 972-6472.